



Doing Business with First Steps: Enrollment, Documentation, & Billing Guide

Posted May 2015



Kentucky Public Health
Prevent. Promote. Protect.



Table of Contents

| | | Page |
|------------------|--|-----------|
| Section A | Enrollment & Professional Conduct | |
| A-I | Early Intervention Overview | 4 |
| A-II | Enrolling as a Provider in First Steps | 6 |
| | A. Early Intervention Services and Provider Types | 6 |
| | B. Enrollment Steps | 8 |
| | C. Disenrollment from First Steps 1. Provider Disenrollment (voluntary) 2. State Lead Agency Disenrollment (involuntary) 3. Failure to Renew Contract (voluntary) | 13 |
| A-III | Roles and Responsibilities of Early Intervention Providers | 15 |
| | A. Provider Responsibilities | 16 |
| | B. Professional Conduct 1. Code of Ethical Conduct 2. Confidentiality: IDEA/FERPA/HIPAA 3. Electronic Communication a. Email b. Texting c. Social Media | 16 |
| Section B | Service Delivery & Documentation | 18 |
| B-I | Referral for Service A. Referral for Services Process B. Provider Matrix | 18 |
| B-II | Authorization for Services (IFSP) A. Accepting Authorization B. Changing Authorization C. Terminating (Discharging) Services-Notice D. Using Interpreters | 20 |
| B-III | Documentation Requirements and Timelines A. Reports B. Assessment Data entry in KEDS C. Six-month, Annual and Exit Progress Reports D. Exit Documentation E. General Documentation Requirements—Service Logs F. Missed Visits G. Late Service Log Entry | 21 |
| Section C | Billing & Reimbursement | 24 |
| C-I | Submitting Claims for Early Intervention Services | 24 |
| | A. Billing and Reimbursement Requirements 1. NPI Number 2. Federal Tax Identification 3. Enrollment with Insurance as a Provider | 24 |
| | B. Submission of Claim for Service on Account Payable Screen 1. Creating a Claim for Payment 2. Claims Processing by First Steps | 25 |

| | | |
|-----------------|---|----|
| | 3. Payment 4. Tracking Payments | |
| C-II | Billing when Insurance is Payor 1 | 28 |
| | A. Co-Payments and Deductibles. | 28 |
| | B. Billing Insurance 1. Explanation of Benefits 2. Insurance Denials | 28 |
| | C. Tracking Payments | 30 |
| | D. Claim Adjustment Overpayment or Underpayment | 30 |
| | E. Insurance Billing Errors | 30 |
| | F. Insurance Payments to Families | 31 |
| | G. Submitting EOBS to the State Lead Agency | 31 |
| | H. Faxing EOBS | 33 |
| | I. Insurance Audits/Quality Assurance | 33 |
| Appendix | <ul style="list-style-type: none"> • Important Contact Information • CMS 1500 Instructions • CPT[®] Codes • TIBS | 36 |

Section A: Enrollment & Professional Conduct

A-I: Early Intervention Overview

First Steps is Kentucky's Early Intervention System (KEIS). Early Intervention (EI) is Part C of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) and is a developmental program serving children birth to three with significant developmental delays and disabilities. Services are authorized based upon functional outcomes that focus on child development and family training, education and support that address developmental needs rather than medical needs. Part C requires states to provide services in "Natural Environments". Natural Environments are defined as "settings that are natural or normal for the child's same-age peers who have no disabilities".

Early Intervention services in First Steps are based upon the following tenets:

- Families are viewed as the primary interventionist in the child's life and expert on the child and family needs;
- Families and service providers establish a partnership with open exchanges of information; and,
- Developmental activities are embedded in the child's everyday life to enhance acquisition of functional skills.

Federal Regulations (34 CFR 303.13 (a)) define Early Intervention Services. *Early intervention services* means developmental services that—

- (1) Are provided under public supervision;
- (2) Are selected in collaboration with the parents;
- (3) Are provided at no cost, except where Federal or State law provides for a system of payments by families, including a schedule of sliding fees;
- (4) Are designed to meet the developmental needs of an infant or toddler with a disability and the needs of the family to assist appropriately in the infant's or toddler's development, as identified by the Individualized Family Service Plan (IFSP) team, in any one or more of the following areas, including—
 - (i) Physical development;
 - (ii) Cognitive development;
 - (iii) Communication development;
 - (iv) Social or emotional development; or
 - (v) Adaptive development;
- (5) Meet the standards of the State in which the early intervention services are provided, including the requirements of Part C of the Individuals with Disabilities Education Act of 2004;
- (6) Include the services identified in the Individuals with Disabilities Education Act of 2004;
- (7) Are provided by qualified personnel;
- (8) To the maximum extent appropriate, are provided in natural environments; and
- (9) Are provided in conformity with an IFSP.

Further, the responsibility of early intervention service providers is defined (34 CFR 303.12 (b)) as:

- (1) Participating in the multidisciplinary IFSP team's ongoing assessment of an infant or toddler with a disability and a family-directed assessment of the resources, priorities, and concerns of the infant's or toddler's family, as related to the needs of the infant or toddler, in the development of integrated outcomes for the IFSP;
- (2) Providing early intervention services in accordance with the IFSP of the infant or toddler with a disability; and
- (3) Consulting with and training parents and others regarding the provision of the early intervention services described in the IFSP of the infant or toddler with a disability.

The U. S. Department of Education, Office of Special Education Programs (OSEP) is responsible for oversight of Part C programs. OSEP monitors programs through the State Performance Plan (SPP) and Annual Performance Report (APR).

The Cabinet for Health and Family Services (CHFS), Department of Public Health, Division of Maternal and Child Health, Early Childhood Development Branch is the State Lead Agency (SLA) for the Kentucky Early Intervention System (KEIS), commonly known as First Steps.

Local lead agencies are designated as Point of Entry (POE). The agencies that have this designation operate under contract to provide child find services (screening and evaluation) and service coordination in fifteen (15) regions of the state. Service Coordinators are employees of the POE.

First Steps is a fee-for-service system. Evaluation, assessment and early intervention services are provided in First Steps through contracts with agencies and individuals. These contracts give the SLA the authority necessary to fulfill all IDEA requirements for general supervision and monitoring as well as establish the business relationship between the SLA and provider. In a fee-for-service system, the service must be provided prior to billing for the service.

An online database management system known as TOTS, Technology-assisted Observation and Teaming Support System serves as the early intervention record and provides a method for communication between early intervention service providers. TOTS also serves as the financial system for providers and SLA.

The purpose of this manual is to provide specific information that affects providers in their practice and business relationship with the SLA. There are other documents that early intervention providers must be familiar with in order to successfully work in First Steps:

- **First Steps Policy and Procedures Manual** (<http://chfs.ky.gov/dph/firstSteps/pptablecontents.htm>)
- **First Steps Code of Ethical Conduct** (<http://chfs.ky.gov/dph/firstSteps/needed+discipl.htm>)
- **State Performance Plan and Annual Performance Reports**
(<http://chfs.ky.gov/dph/firstSteps/First+Steps+Annual+Reports.htm>)
- **State Regulations 902 KAR 30:001-30:200** (<http://chfs.ky.gov/dph/firstSteps/pptablecontents.htm>)
- **Federal Regulations 34 CFR 303** (<http://www.gpo.gov/fdsys/pkg/FR-2011-09-28/pdf/2011-22783.pdf>)
- **TOTS User Guide** (<https://www.kytots.org/tots/>)

A-II: Enrolling as a Provider in First Steps

A. Early Intervention Services and Provider Types

The professionals contracted to work in First Steps perform a variety of services. For full descriptions of early intervention services, see federal regulations 34 CFR 303.13 (b) and state regulations 902 30:150.

Early Intervention Services

Assistive Technology services directly assist a child with a disability in the selection, acquisition, or use of an assistive technology device. An assistive technology device is any item, piece of equipment or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain or improve the functional capabilities of a child with a disability.

Audiology services include identification of an auditory impairment through screening and testing and the provision of auditory training, aural rehabilitation, speech reading, listening device orientation and training. This service also includes the determination of need for individual amplification and the subsequent evaluation of the effectiveness of those devices.

Developmental Intervention services address the acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction skills.

Family Training and Counseling services are provided to assist the family in understanding the special needs of the child and how the family can enhance the child's development through daily routines in the home environment.

Health Services are services necessary to enable a child to benefit from the provision of other early intervention services. This includes clean intermittent catheterization, tracheostomy care, tube feeding, etc.

Nursing services include assessment of health status and provision of nursing care required for the child to benefit from Early Intervention Services during the time the child receives the Early Intervention Services.

Nutrition services address assessment of nutritional history and dietary intake, feeding skills and feeding problems, food habits and preferences.

Occupational Therapy services address the functional needs of a child related to adaptive development, adaptive behavior and play, as well as sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home and community settings.

Physical Therapy services address the assessment of gross motor skills and disorders of movement and posture and treatment through a variety of modalities. This service is designed to promote effective environmental adaptations.

Sign and Cued Language services include teaching sign language, cued language, and auditory/oral language, providing oral transliteration services (such as amplification), and providing sign and cued language interpretation.

Speech Language services address the speech and/or language development through identification and treatment of children with communicative or oral motor disorder. Specific delays and disorders may include articulation, receptive and expressive language, and fluency and voice problems.

Psychology services includes: 1) administering psychological and developmental tests and assessments, 2) interpreting assessment results, 3) obtaining, integrating and interpreting information about child behavior and child and family conditions related to learning, mental health and development, and 4) planning and managing a program of psychological services including psychological counseling for children and parents, consultation on child development, parent training, and education programs.

Medical services are only for diagnostic or evaluation purposes and are performed by a licensed physician to determine a child's developmental status and need for Early Intervention Services.

Early Intervention Provider Types

First Steps maintains contracts with a variety of service specialist to meet the needs of children and families. All contracted early intervention providers must be approved by CHFS in accordance with KRS 200.666 (1).

Minimum Qualifications

| Provider Type | Credential/Degree | License or Certificate |
|---|--|--|
| Audiologist | Master's Degree | Licensed by the Kentucky Board of Speech-Language Pathology and Audiology. |
| Assistive Technology Specialist | | Must meet the minimum highest entry-level requirements for one (1) of the professions delineated in 902 KAR 30: 150; and (ii) Have extensive knowledge, training, and experience in the field of assistive technologies for infants and toddlers with disabilities; or b.(i) Meet the qualifications established in clause a.(ii) of this paragraph; and (ii) Be employed by an agency that currently provides assistive technology service in First Steps. |
| Developmental Interventionist (DI) | Bachelor's Degree | Certified in Interdisciplinary Early Childhood Education (IECE) as issued by the Kentucky Education Professional Standards Board, Division of Certification, a probationary or emergency IECE certificate issued by the Educational Professional Standards Board; or a valid statement of eligibility for IECE certification issued by the Kentucky Educational Professional Standards Board, Division of Certification. |
| Family Therapist | Master's Degree | Licensed by the Kentucky Board of Licensure of Marriage and Family Therapists. |
| Licensed Professional Clinical Counselor (LPCC) | Master's Degree | Licensed by the Kentucky Board of Licensed Professional Counselors |
| Registered Dietician | Bachelor's Degree | Licensed by the Kentucky Board of Licensure and Certification for Dietitians and Nutritionists. |
| Nurse, RN | Associate's degree or diploma from a registered program | Licensed by the Kentucky Board of Nursing. |
| Occupational Therapist (OT) | Bachelor's degree | Licensed by the Kentucky Board of Licensure for Occupational Therapy |
| Occupational Therapy Assistant (OTA) | Associate's degree in occupational therapy | Licensed by the Kentucky Board of Licensure for Occupational Therapy |
| Orientation and Mobility Specialist | Bachelor's degree in special education with emphasis on visual impairment and orientation and mobility | Certified in visual impairments issued by the Educational Professional Standards Board |
| Physical Therapist (PT) | Bachelor's degree | Licensed by the Kentucky Board of Physical Therapy |
| Physical Therapy Assistant (PTA) | Associate's degree in physical therapy assistance | Licensed by the Kentucky Board of Physical Therapy. |
| Physician, including Ophthalmologist | Doctor of medicine degree or doctor of osteopathy degree or doctor of optometry | Licensed by the Kentucky Board of Medical Licensure |
| Optometrist | Degree from an accredited school or college of optometry | Licensed by the Kentucky Board of Optometric Examiners |
| Psychologist | Doctoral degree | Licensed by the Kentucky Board of Examiners of Psychology. |
| Certified psychologist with autonomous Functioning; or | Master's degree | License or certificate by the Kentucky Board of Examiners of Psychology |

| | | |
|--|-------------------|---|
| Licensed psychological practitioner; or Certified psychologist or licensed psychological associate | | |
| Respite Provider | | A respite provider shall: 1. Meet all license, administrative regulations, and other requirements applicable to the setting in which respite is provided; and 2. Be approved by the individualized family service planning team. |
| Sign Language and Cued Language Specialist | | A valid certification as established by 201 KAR 39:030 |
| Social Worker | Bachelor's degree | Licensed by the Kentucky Board of Social Work |
| Speech Language Pathologist (SLP) | Master's degree | Licensed by the Kentucky Board of Speech-Language Pathology and Audiology or Temporarily licensed from the Kentucky Board of Speech-Language Pathology and Audiology and under the supervision of a currently-enrolled First Steps speech-language pathologist. |
| Teacher of the Deaf and Hard of Hearing | Bachelor's degree | A certificate for teaching the hearing impaired, or a certificate for teaching the hearing impaired with sign language proficiency, grades P-12, issued by the Kentucky Education Professional Standards Board, Division of Certification. |
| Teacher of the Visually Impaired | Bachelor's Degree | Certified for teaching of the visually impaired, grades P-12 Or Certified for teaching the partially seeing, blind, or visually impaired, K-12 issued by the Kentucky Education Professional Standards Board, Division of Certification. |

B. Enrollment Steps

Enrollment as a provider of early intervention in First Steps is a multi-phase process. Before beginning the process, interested individuals need to first determine the provider type for which they wish to apply and ensure that they meet the qualifications for that provider type. The types and qualifications for each provider type can be found in state regulations, 902 KAR 30:150, Personnel Qualifications (<http://chfs.ky.gov/dph/firstSteps/pptablecontents.htm>).

Potential providers are encouraged to determine the need for local services by the provider type in the area to be served. Contact the local Point of Entry (POE) office in the area you want to provide First Steps services to determine if there is a need for your services in that location. Contact information can be found at: <http://chfs.ky.gov/dph/firstSteps/helpfulstaff.htm>. Enrollment as a provider in First Steps is not a guarantee of a specific caseload of children to serve or a guarantee of full-time work.

Provider enrollment steps are outlined on the following pages (9-). The process for independent and agency enrollment is detailed as well as the process for adding new providers to an existing contract.

FIRST STEPS PROVIDER ENROLLMENT

There are two types of provider enrollment: enrollment as an independent provider (one provider only working under contract with First Steps) or enrollment as an agency (more than one provider working under the same company that holds the contract with First Steps). The information below outlines the steps for both types of enrollment. Also included is how an existing agency adds new staff to their First Steps contract.

Prior to enrolling with First Steps, new businesses may need to register with both the Secretary of State and the Department of Revenue. New businesses can apply online for the tax accounts and also with the Kentucky Secretary of State's Office using the Kentucky Business One Stop [Online Business Registration](#).

STEP I Provider requests a Provider Application from the State Lead Agency (SLA) by email:

- Independent Provider requests the [Individual Provider Application \(RF 6A \(I\)\)](#) which includes the forms listed under Step II.
- Agency with multiple employees requests the [Agency Application \(RF 6A \(A\)\)](#) which includes the forms listed under Step II.

STEP II Provider completes and submits the following:

A. New Independent Provider:

- Fully completed Individual Provider Application RF 6A (I) (Including Federal Tax ID and NPI numbers; these are used for billing. (Please see Section C-I. A and B for more information)
- Copy of professional licensure (with expiration date)
- Copy of Professional Liability Insurance
- Discipline Code (This is a two digit code that is included in the application packet)
- Two (2) Background Check forms
 - Administrative Office of the Courts (AOC): The AOC provides criminal record reports for a nominal fee (currently \$20.00). Information comes from a database of court records for all Kentucky counties. Included in the database are misdemeanors and traffic cases for at least five (5) years and felony cases since 1978. Reports can be requested online or in person. For more information and request forms, see the website at: <http://courts.ky.gov/aoc/criminalrecordreports/Pages/default.aspx>
 - Division of Protection and Permanency (DPP): The DPP provides background checks for child abuse and neglect for a current fee of \$10.00. The DPP-156 form (also available at <http://chfs.ky.gov/dpbs/dafm/>) must be completed and submitted with payment to DPP, Records Management Section.

The two (2) background checks must be submitted directly to the SLA by those agencies. The SLA will conduct additional checks with the Kentucky Medicaid Terminated and Excluded Provider List and the Sex Offender Registry.

B. New Agency with Multiple Providers:

- Fully completed Agency Provider Application RF 6A (A) (Including Federal Tax ID and NPI numbers)
- Copy of professional licensure (with expiration date) for each employee and/or subcontractor
- Copy of Professional Liability Insurance for the agency or for each employee and/or subcontractor if the agency requires individuals to carry their own liability insurance
- Discipline Code (included in the application packet) for each employee and/or subcontractor
- Two (2) Background Check forms
 - Administrative Office of the Courts (AOC): The AOC provides criminal record reports for a nominal fee (currently \$20.00). Information comes from a database of court records for all Kentucky counties. Included in the database are misdemeanors and traffic cases for at least five (5) years and felony cases since 1978. Reports can be requested online or in person. For more information and request forms, see the website at: <http://courts.ky.gov/aoc/criminalrecordreports/Pages/default.aspx>

- Division of Protection and Permanency (DPP): The DPP provides background checks for child abuse and neglect for a current fee of \$10.00. The DPP-156 form (also available at <http://chfs.ky.gov/dCBS/dafm/>) must be completed and submitted with payment to DPP, Records Management Section.

The two (2) background check results must be submitted directly by those agencies to the SLA. The SLA will conduct additional checks with the Kentucky Medicaid Terminated and Excluded Provider List and the Sex Offender Registry.

STEP III Initial Training

Once Step II is completed and the SLA has reviewed all background checks, the prospective provider must complete the next steps of the process which is initial training. There are two (2) training requirements at this point in the enrollment process:

- a. Online training modules: The prospective provider is registered in the Adobe Connect training system and notified that they may access the initial required training, *New Provider Modules 1-4*. The modules must be completed within ninety (90) days of receipt of the email from the SLA announcing registration in Adobe Connect. Once completed, the provider must notify the SLA of completion.
- b. After the SLA verifies completion of the *New Provider Modules 1-4*, the prospective provider is registered for the Face-to-Face Orientation held in Frankfort. The provider is instructed to submit the Certificates of Completion with the paperwork received at Face-to-Face Orientation.

STEP IV Required forms for finalizing enrollment after completing Step III

The SLA staff conducting the face-to-face Orientation session gives the attendees a packet with the required final forms for completion. The packets are specific as to how the provider is enrolling administratively— independent or with an agency. **All forms requiring an original signature may not be faxed to the SLA.** It is recommended that the provider make and keep copies of all paperwork submitted.

A. Independent provider forms (These forms must be submitted by hard copy mail; faxed forms will not be accepted)

- Service Provider Agreement (signed by the provider as the Agency Administrator).
- Business Associate Agreement (BAA; must be signed by the provider as the Agency Administrator).
- Required Affidavit for Bidders, Offerors and Contractors (must be signed and notarized).
- Code of Ethical Conduct (signed and dated).
- Financial forms: These are provided at the face-to-face orientation. In addition, both forms are available at <http://chfs.ky.gov/dph/firstSteps/needed+discipl.htm>
 - Direct Deposit (SAS 63)
 - IRS W-9
- Signature on File (labeled as RF-23; must be signed and dated).
- Service Catchment Area 2014

B. New Agencies with multiple providers will receive and submit:

Do not fax the following forms:

- Service Provider Agreement (signed by the Agency Administrator).
- Business Associate Agreement (BAA; must be signed the Agency Administrator).
- Affidavit for Bidders, Offerors, and Contractors (must be signed and notarized).
- Financial forms: These are provided at the Face-to-Face orientation. In addition, both forms are available at <http://chfs.ky.gov/dph/firstSteps/needed+discipl.htm>
 - Direct Deposit (SAS 63)
 - IRS W-9

Agency Administrator must submit the forms listed below for each individual who will be working in First Steps. Do not fax the following forms:

- Code of Ethical Conduct (signed and dated).
- Signature on File (labeled as RF-23; must be signed and dated).
- Service Catchment Area 2014

STEP V Provider Receives Finalized Contract

Once all paperwork provided at the Face-to-Face Orientation training is received by the SLA and is correctly completed, the SLA will send the signature page of the fully executed Service Provider Agreement to the agency administrator.

STEP VI TOTS Logon and Additional Required Training

The provider will receive an email containing their TOTS user id and password. This email will also contain a chart of required trainings and the timeline for completion. The provider must complete the following trainings within **30 days of their contract start date**:

1. Record Keeping and Confidentiality;
2. TOTS;
3. First Steps Provider Matrix; and
4. Consultative Model which includes:
 - A. Family Assessment in Part C
 - B. Functional Outcomes;
 - C. Consultative and Primary Service Provider; and
 - D. Coaching Principles and Practices.

Note: Failure to complete these required trainings within the stated timeline will result in contract termination.

Providers must also complete training on at least one of the approved assessment instruments for measuring child outcomes within ninety (90) days of the contract start date:

1. *Hawaii Early Learning Profile (HELP)*
2. *Assessment, Evaluation, Programming System (AEPS)*
3. *Carolina Curriculum for Infants and Toddlers with Special Needs (CCITSN)*

Agencies Adding New Providers to an Existing First Steps Contract

STEP I Agency Administrator submits to the SLA:

- Form 6 Addendum
- Page 4 of the Agency Application RF 6A (A) which includes the Discipline Code
- Copy of prospective provider's professional license (including expiration date)
- Copy of the professional liability insurance or for each employee and/or subcontractor if the agency requires individuals to carry their own liability insurance
- Two (2) Background Check forms for the prospective provider:
 - Administrative Office of the Courts (AOC): The AOC provides criminal record reports for a nominal fee (currently \$20.00). Information comes from a database of court records for all Kentucky counties. Included in the database are misdemeanors and traffic cases for at least five (5) years and felony cases since 1978. Reports can be requested online or in person. For more information and request forms, see the website at: <http://courts.ky.gov/aoc/criminalrecordreports/Pages/default.aspx>
 - Division of Protection and Permanency (DPP): The DPP provides background checks for child abuse and neglect for a current fee of \$10.00. The DPP-156 form (also available at <http://chfs.ky.gov/dpbs/dafm/>) must be completed and submitted with payment to DPP, Records Management Section.

The two (2) background checks result must be submitted directly to the SLA by those agencies. The SLA will conduct additional checks with the Kentucky Medicaid Terminated and Excluded Provider List and the Sex Offender Registry.

STEP II Initial Training

Once Step II is completed and the SLA has reviewed all background checks, the prospective provider must complete the next step of the process which is initial training. There are two (2) training requirements at this point in the enrollment process:

a. Online training modules: The prospective provider is registered in the Adobe Connect training system and notified that they may access the initial required training, *New Provider Modules 1-4*. The modules must be completed within ninety (90) days of receipt of the email from the SLA announcing registration in Adobe Connect. Once completed, the provider must notify the SLA of completion. If the training is not completed within ninety (90) days, the enrollment is null and void.

b. After the SLA verifies completion of the *New Provider Modules 1-4*, the prospective provider is registered for the Face-to-Face Orientation held in Frankfort. The provider is instructed to submit the Certificates of Completion with the paperwork received at Face-to-Face Orientation.

STEP III Required forms for finalizing enrollment after completing Step II

The SLA staff conducting the Face-to-Face Orientation session will give the attendees a packet with the required final forms for completion. All forms requiring an original signature may not be faxed to the SLA. It is recommended that the agency keep copy of all paperwork submitted to the SLA.

Agency Administrator must submit the forms listed below for each individual who will be working in First Steps. Do not fax the following forms:

- Code of Ethical Conduct (signed and dated).
- Signature on File (labeled as RF-23; must be signed and dated).
- Service Catchment Area 2014

STEP V Provider Receives Finalized Contract

Once all paperwork provided at the Face-to-Face Orientation training is received by the SLA and is correctly completed, the SLA will send the signature page of the fully executed Service Provider Agreement to the agency administrator.

STEP VI TOTS Logon and Additional Required Training

The provider will receive an email containing their TOTS user id and password. This email will also contain a chart of the required trainings and the timeline for completion. The provider must complete the following trainings within **30 days of their contract start date:**

1. Record Keeping and Confidentiality;
2. TOTS;
3. First Steps Provider Matrix; and
4. Consultative Model which includes:
 - A. Family Assessment in Part C
 - B. Functional Outcomes;
 - C. Consultative and Primary Service Provider; and
 - D. Coaching Principles and Practices.

Providers must also complete training on at least one of the approved assessment instruments used in First Steps to measure child outcomes within ninety (90) days of the contract start date:

- 1) *Hawaii Early Learning Profile (HELP)*
- 2) *Assessment, Evaluation, and Programming System (AEPS)*

3) *Carolina Curriculum for Infants and Toddlers with Special Needs* (CCITSN)

Information where to access this training is provided at the Face-to-Face Orientation. **Note:** Failure to complete these required trainings within stated timelines will result in contract termination.

C. Disenrollment from First Steps

There are three types of disenrollment as a provider in First Steps:

1. Provider Disenrollment (Voluntary)

If a provider decides to no longer provide service to children in the First Steps system, the following activities are necessary:

1. The provider must notify the Service Coordinator of his/her disenrollment so the Service Coordinator can assist the family with selecting another provider.
2. All authorizations must be cancelled with the appropriate date.
3. The provider must provide a thirty (30 day) notice to the SLA to exit from the system by submitting a Form 6 Addendum.
4. All documentation and billing must be entered into the statewide data management system within sixty (60) calendar days of submitting the disenrollment paperwork.
5. After sixty (60) calendar days, the provider's user ID and password for the statewide data management system will become inactive. Any services not documented by this date cannot be billed.

2. SLA Disenrollment of Provider (Involuntary)

The SLA reserves the right to terminate a provider agreement for any reason. If a provider is disenrolled by the SLA, the following steps are taken:

1. The SLA notifies the provider of the termination and deadline for inactivation of the TOTS ID and password by certified mail.
 - a. All documentation and billing must be entered into the statewide data management system within sixty (60) calendar days of the disenrollment date.
 - b. After sixty (60) calendar days, the provider's user ID and password for the statewide data management system will become inactive. Any services not documented by this date cannot be billed.
2. The provider must notify the Service Coordinator, who will assist the family with selecting a new provider.

Through program monitoring there may be times the SLA will recommend disciplinary action against a provider that works under an agency contract (subcontractor status). General supervision staff will work with the contract administrator to ensure a timely resolution should such an incident arise.

3. Failure to Renew Contract

First Steps contracts are for a period of time that matches the state budget period. This means that the service provider agreements (contracts) are issued for a maximum of two years beginning July 1 of even-numbered years. The end date of a service agreement will be the end date for the state budget period in which the agreement is executed. Providers who choose to not renew their contract with First Steps are voluntarily disenrolling from the early intervention system. The following activities are necessary:

1. The provider must notify the Service Coordinator of the decision to not renew the contract so the Service Coordinator can assist the family with selecting another provider.
2. All authorizations must be cancelled with the appropriate date.
3. The provider must provide a thirty (30 day) notice of exit to the SLA by submitting a Form 6 Addendum.
4. All documentation and billing must be entered into the statewide data management system within sixty (60) calendar days of submitting the disenrollment paperwork.
5. After sixty (60) calendar days, the provider's TOTS user ID and password will become inactive. Any services not documented by this date cannot be billed.

A-III: Roles & Responsibilities of Early Intervention Providers

Early intervention promotes a child's growth and development and supports the family during the critical early years. The primary role of a First Steps provider is to work collaboratively with the family, child, and IFSP team members. First Steps incorporates the information from the family assessment to identify the family's priorities, concerns, and needs regarding their child's development. Providers and other IFSP team members use this information to identify the services needed to achieve the outcomes. Listed below are the typical roles in which a service provider will engage:

- 1) Consultant—this will be with a family member, service provider, Service Coordinator, and/or a representative of a community agency to ensure the attainment of identified outcomes.
- 2) Teacher—this will be with a family, other IFSP team members and other caregivers, teaching different strategies necessary to attain an identified outcome.
- 3) Team Member—this will be at team meetings to assist the team with its responsibilities.

First Steps uses a primary service provider (PSP) model of service delivery. One IFSP team member is selected to provide the majority of visits to the child and family. The PSP model of intervention is a concept that shifts the focus of the intervention off the child with the disability and emphasizes supporting those people involved with the child across a variety of environments. The PSP is the primary coach. This approach focuses on promoting the child's and family's assets and interests within the context of natural learning opportunities using coaching conversations. (*Using Primary Service Providers & Coaching in Early Intervention Programs*, Kansas In-service Training System; <http://www.kskits.org/ta/Packets/UsingPrimaryService.shtml>)

A. Provider Responsibilities

- 1) Provide early intervention services in compliance with all applicable federal and state laws and regulations including laws related to privacy and confidentiality.
- 2) Adhere to all reporting requirements, including completion of complete and timely service logs in the statewide data management system (TOTS) that describes all contacts with the family and child.
- 3) Maintain a hard copy file for a minimum of six (6) years, which contains all consents and releases with original parent or guardian signatures.
- 4) Participate and fully cooperate with any general supervision management activities as required by the State.
- 5) Complete required training.

By state law all First Steps providers are mandated reporters for suspected abuse and neglect. State law, House Bill 285 (<http://www.lrc.ky.gov/record/10rs/hb285.htm>) also requires home visitors to complete training on Pediatric Abusive Head Trauma. Specific training to fulfill this obligation is provided by many of the licensing boards and/or state associations for various disciplines. Providers may also access an online training at the ECE-TRIS website. Login following the directions for the username and password at this website: <https://tris.eku.edu/ece/>.

B. Professional Conduct and Ethics

1. Code of Ethical Conduct

All First Steps providers are accountable for their conduct. Providers represent both the program and their profession. All professions have a code of conduct embedded in their respective practice acts. The First Steps Code of Ethical Conduct outlines the general expected behavior of First Steps representatives. All providers, including service coordinators, must sign and date the First Steps Code of Ethical Conduct when enrolling in the system.

Providers are expected to conduct themselves with honesty, integrity, objectivity, and respect when engaged in First Steps services with families and other IFSP team members. Professional boundaries must be maintained between the provider and family. These are more fully described in the First Steps Code of Ethical Conduct.

The First Steps Code of Ethical Conduct is enforceable by the SLA and violations of the Code of Ethics may result in contract termination. Providers are prohibited from conducting any non-First Steps business transactions with the families that they are serving in First Steps. Complaints concerning the behavior of a First Steps provider are investigated

by the SLA. Investigations include interviewing those involved about the behavior and a review of documentation. Ethical violations may also involve billing reviews if billing irregularities are related to the complaint.

2. Conflict of Interest

Individuals who meet the qualifications for two different disciplines may enroll in First Steps under both disciplines; however, they may not work as both in the same POE district. The individual may only work under one discipline in one POE and serve a different POE as the other discipline. One person cannot provide evaluation and assessment and direct services to the same child and family as two different disciplines.

A provider cannot provide ongoing services to a child when he/she conducted the initial evaluation.

3. Confidentiality: IDEA/FERPA/HIPAA

Services provided to eligible children and their families through First Steps are covered under the confidentiality and record keeping provisions of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA; 34 CFR 303.401-303.417), Family Educational Rights and Privacy Act of 1974 (FERPA; 34 CFR 99.31) and the and the Health Insurance Portability and Accountability Act of 1996 (HIPAA; 45 CFR Part 160 and Part 164, Subparts A and E). Providers are required to comply fully with all acts; however, there are specific required provisions within HIPAA outlined below:

- 1) Providers must develop or use the First Steps **Notice of Privacy Practices** that outlines the information collected from families, how that information will be used and the requirements for disclosure of the collected information.
- 2) Providers are required by HIPAA to obtain a National Provider Identifier (NPI) number prior to contract approval. Providers obtain an NPI and submit this with enrollment paperwork.

4. Electronic Communication

Electronic communication (emails, faxes, text messages, Facebook, LinkedIn and other social networking sites) is increasingly being used as a means of communication between providers and families. First Steps does not recommend that electronic communication be used with families. Caution must always be taken whenever using any form of electronic communication for the following reasons: use of personal email, cell phone numbers or personal social network sites can be accessed by others not working with the family; if a complaint leads to an investigation, all electronic communication records (including personal email accounts) could be requested through the Freedom of Information Act. Finally, the use of electronic communication may make maintaining professional boundaries more difficult by allowing both families and providers access to personal cell phones, emails and texts at all hours of the day and night.

The discussion of the use of social network sites should occur during the initial visits with the family. Email and faxes may be used when supported by an encrypted communication system that includes firewalls that are HIPAA compliant. Video messaging such as SKYPE can only be used when supported by HIPAA compliant security. Families should be informed that while their child is receiving services through First Steps the provider will be unable to communicate with them via personal social network sites.

Personally identifiable information such as name, diagnosis, address, etc. must not be included in any electronic communication. All electronic communication with families must be documented in the child's TOTS record in the Communication Log. This includes telephone, email and text messaging.

a. Email:

- Do not use email to provide clinical direction to the family. It should only be used for logistics such as scheduling changes.
- Unprofessional personal email addresses should never be used by providers.
- Joint personal e-mail addresses, in which two or more individuals share one email address, must not be used when communicating with families or other IFSP team members.
- Careful attention should be paid to the address the email is being sent to in order to avoid sending the email to an unintended recipient.

- Read the email carefully before sending. Check that all personal information about the family is de-identified.
- Keep messages short, clear and concise and encourage families to do the same.
- The signature at the end of the email should include full name, email address, work address, phone number and job description (i.e. Occupational therapist, BCBA)
- Never use all capital letters. This is the online equivalent of shouting.
- Avoid using the words urgent and important in the subject line.
- The use of a confidentiality disclaimer at the bottom of emails sent to or about families is mandatory.

b. Texting:

- Always ask permission from a family before texting them. Some phone plans may not cover texting or may charge for each text sent. Or the family may prefer voice messages left on their phone.
- Use text messages sparingly, for example, to update families on a change in appointment time.
- Always end the text with your first and last name. Do not assume the family has your name as a contact in their phone or will recognize your telephone number.
- Make sure all information in the text is de-identified and does not contain any personal information about the family.
- Keep the text strictly professional. Do not use texting shorthand assuming the family will understand. Do not use slang or all capital letters.
- Do not respond to a telephone call with a text message.
- Do not send text messages late in the evening or early in the morning.
- Careful attention must be paid to the telephone number the text is being sent to in order to avoid sending the text to an unintended recipient.
- Do not check text messages or answer text messages while with a family. It is just as rude as talking on the telephone.
- Do not rely on text messaging with families as the sole form of communication with them.

As with emails, text messages are considered part of the record and must be included in the record. If your phone does not allow you to email a text message where it can be printed out or archived where it can be retrieved, do not communicate with families via text.

c. Social Media:

Use of social media is not allowable in First Steps. If social media is used by an individual in their life outside of the professional role in First Steps, care must be taken that no confidential information from First Steps is posted on a social media site. Please be aware of the following:

- Maintain professional boundaries in the use of social media. The fact that the family may initiate contact does not permit First Steps providers to engage in a personal relationship with the family.
- Do not share, post, or otherwise disseminate any information (including images) about a child or family or information gained while in contact with the family. Do not identify children or families by name or post or publish information that may lead to identification of the child or family. Limiting access to postings through privacy settings is not sufficient, even if the child or family is not identified.
- Do not refer to the child or family in a disparaging manner, even if they are not referred to by name.
- Do not take photos or videos of children or families on personal devices, including cell phones.
- Promptly report any identified breach of confidentiality or privacy.

Section B: Service Delivery and Documentation Requirements

B-I: Referral for Service

A: Referral for Services Process

First Steps providers must accept First Steps client referrals without discrimination for race, ethnicity, language used by the family, disability, family status, location of residence, and financial resources (public or private insurance coverage).

Enrolled providers are not guaranteed a set number of referrals. Referrals to providers are based on the needs of the child and family as identified through the IFSP outcomes process.

B. Provider Matrix

This matrix is an online public directory of all Primary Level Evaluators, and early intervention providers who are enrolled with First Steps. The purpose of the Provider Matrix is to have an easily accessible source for information about the individuals who provide services to children and families. The Provider Matrix includes basic provider enrollment data from TOTS. There are additional sections that agency administrators complete. Parents have access to the Provider Matrix to help them make an informed choice of provider.

Provider Information entered by the provider

There are sections of the matrix page where providers (agency administrators) enter information by using the Edit/Find User button on the homepage. These sections include languages spoken, personal information, special interests and training, and availability for services. All information entered by the provider must be accurate. Upon request, the provider must be able to submit verification for information listed on the matrix.

To access the page, first click on Edit/Find User on the homepage. A listing of all providers associated with that administrator logon will appear. The next step is to click on the "Update" button by the provider's name.

User Information: The first section is used by the SLA and is pre-filled when the page opens. Any item that is gray is locked and cannot be changed by the user. The user is able to change any item #4-13 by submitting a Form 6 Addendum to the State Lead Agency. Failure to submit a Form 6 Addendum will result in no payment since there is critical information on the Form 6 that must be entered in the state's procurement database.

Additional Information for Service Provider and Service Coordinator: only items 13-15, 17, and 19-21 may be changed. Items #13, 14, and 15 are text boxes that the agency administrator completes.

Items 19 and 20 are the availability data. These must be kept current. The State Lead Agency recommends that review or updates occur monthly or more often as needed. The agency administrator must review and update individual Provider Matrix pages at a minimum of every 90 days. There is no limitation to the number of reviews or updates.

Providers who have not reviewed and/or revised Provider Matrix information at least once during a 90-day period will result in the agency being suspended from referrals until the update is completed.

Misrepresentation of information on the matrix may be viewed as grounds for involuntary disenrollment from the First Steps program.

The Provider Matrix is to be limited to experience, training and qualities important in selecting a provider. Comments must be professional and nondiscriminatory. Experience must be professional experience that is comparable to the current specialty or discipline of the provider. Only experience in the field in which the provider is currently providing service is to be listed as experience.

Comments relating to marketing or that do not relate to the individual qualities and training of the provider is not to be included on the matrix.

Acceptable for the Personal Information section:

- Number of years working in First Steps
- Number of years working with B-5 age groups and in what capacity
- Areas of professional interest
- May include if a parent of a child with a disability or who was in First Steps

Not Acceptable for the Personal Information section:

- Family composition, marital status
- Type of religion, religious beliefs
- Social media addresses, connections
- Volunteer work
- Hobbies
- Work experience not relevant to early intervention
- Solicitations for business of any sort, including services for children over the age of three (3)

Acceptable for the Special Interests/Training section:

- Areas for interventions (i.e., feeding, swallowing, sign language, etc.)
- Types of disabilities or diagnoses that are of interest (i.e., autism spectrum disorders, Down Syndrome, etc.)
- Specialized trainings
- College courses, efforts towards advanced degrees
- Experience that is relevant, but not in the field of service may be listed

Not Acceptable for the Special Interests/Training section:

- List of all workshops or trainings completed
- College course work that does not relate to early intervention
- Hobbies

Matrix Maintenance and Update:

- 1) The agency administrator must review and update individual provider matrix pages at a minimum of every 90 days. The State Lead Agency recommends that review and updates occur monthly or more often as needed. There is no limitation to the number of reviews or updates.
- 2) Changes to the contact information on the matrix require a Form 6 Addendum be submitted to the SLA. Failure to do so will result incorrect billing information in TOTS. Payments will be withheld until resolved.
- 3) Availability should reflect the total number of available slots that the provider anticipates in the county(ies) listed.
- 4) Providers who list themselves as available must make every effort to provide services when selected. Only those instances when the provider's availability changed with limited time to update the matrix will be acceptable for refusal of a referral.
- 5) Providers may not discriminate based on race, ethnicity, social or economic status, and/or geographical location within the provider's stated area of service when offered a referral.
- 6) The provider or provider agency assumes responsibility to ensure that the individual matrix pages are accurate and up to date.

NOTE: Agency administrators are responsible for the maintenance of matrix pages for their agency. Matrix pages that are not maintained according to these procedures or pages that contain inaccurate information will result in suspension of referrals to the agency. Repeated suspensions may lead to disenrollment from First Steps.

B-II. Authorization for Services

First Steps services cannot be provided without written, informed consent of the parent or guardian. Service Coordinators obtain the consent before any service provision occurs. Agencies may have an internal policy to obtain an agency-developed consent for services in addition to the First Steps consent.

Never ask a parent or caregiver to sign blank forms for future dates of service. This is not an acceptable practice and could result in a recoupment of funds and and/or the loss of a provider's contract.

A. Accepting Authorization (Planned Services)

Authorizations are needed to provide services. Providers do not enter authorizations in TOTS—this is done by the Service Coordinators. Authorizations are a reflection of the services identified on an IFSP. In TOTS, authorizations are listed as Planned Services. All service providers should have a copy of the IFSP as they begin services for a child and family. Authorizations in TOTS match the services specified on the IFSP including the dates of service, frequency, intensity, location and duration. Authorization start dates must be consistent with the start date identified on the IFSP.

Once a provider accepts an authorization, the provider commits to provision of services based upon a frequency, intensity and duration that have been identified as a need on a child's IFSP. Providers should pay close attention to the start and end dates of the IFSP for accuracy. The authorization must not extend services beyond the end dates if no new IFSP or Planned Services/Authorization has been received. If the provider has a question concerning what has been entered for Planned Services, the provider must contact the service coordinator.

B. Changing Authorizations

A Requested Review IFSP meeting must be held prior to making any changes to an IFSP such as increasing the frequency or intensity of services that were originally identified as a need on the IFSP or changing the location from a natural environment to a non-natural environment. The team must discuss and document the reason for the change and cite the data that supports the decisions. The service coordinator must facilitate the meeting and the parent(s) must be present to request changes to existing authorizations. (See the First Steps Policy and Procedure Manual at <http://chfs.ky.gov/dph/firstSteps/pptablecontents.htm> for more detail on this process).

C. Terminating Services (Discharging)-Notice

All providers are required to give notice to the child's Service Coordinator and the child's family at least five working days prior to terminating or discharging services for an eligible child. There must be sufficient time for a transition plan related to this change in service to be implemented.

D. Use of Interpreters

All children and families have the right to information in their native language. Native language is defined as the language normally used by the parents of the child, except when evaluating or assessing the child. Interpreter services are the responsibility of the provider; however, the SLA is supporting the costs of this service for providers at this time.

The purpose of bilingual interpreters is to interpret services necessary during the rendering of early intervention services to facilitate communication with the child and family. If the interpreter is authorized to interpret service sessions for a provider and family, the interpreter may assist that provider in scheduling service appointments for that family. A provider should never ask an interpreter to call a child's family for any purpose other than to schedule or cancel an appointment. The responsibility of the interpreter is to simply interpret the words of the provider to the family and to interpret the family's response back to the provider. It is not the responsibility of the interpreter to discuss the provision of services with the family when not in the presence of the provider.

B-III Documentation Requirements and Timelines

Effective documentation is critical to the early intervention system process. It serves as a "blueprint" for service provision as well as a means for accountability and provides:

1. A chronological record of the child's status, which details the complete course of intervention;
2. Communication among professionals and the family;
3. An objective basis to determine the appropriateness, effectiveness, and necessity of intervention;
4. The practitioner's rationale for service methods; and,

5. Accountability for payment.

All providers are required to maintain documentation for a period of at least six (6) years from a child's completion of early intervention services and permit access to those records by the SLA.

A. Reports

First Steps issues an authorization for the following reports: initial evaluation and assessment (Primary Level Evaluation or PLE), annual assessment (5AA), and transition or discharge assessment (5AA). First Steps also pays for discipline specific assessment reports that may be required when determined necessary for the IFSP team to more fully address the child's needs.

Progress reports are included in the established rate for the service. There is no additional reimbursement specifically for reports describing progress during the implementation of IFSP services.

B. Assessment Data Entry in KEDS

Item level assessment data is entered into the Kentucky Early Childhood Data System (KEDS) upon entry, annually and at exit. The Initial Evaluator (Primary Level Evaluator or PLE) is responsible for data entry for the initial 5AA; an IFSP team member is responsible for the annual and exit 5AAs. The item level data from the 5AA must be entered in KEDS before payment for the assessment is approved. Once the data is entered and finalized, a verification code of data entry will be issued by KEDS. This code is then included in the file transfer from KEDS to TOTS for payment approval.

C. Six (6) Month, Annual and Exit Progress Report Requirements

Ongoing assessment of the child's progress and response to services shall be documented as part of each service log. The family's ongoing and changing identification of their resources, priorities and concerns as it enhances their child's development should guide the program planning. Personal preferences of the family should direct the methods of gathering this information. Assessment can determine in what way the child's development is atypical, what kinds of intervention may be appropriate, how a child may respond to a particular strategy and if progress or change has occurred in a particular area of development. Ongoing assessment should occur in order for the family and service providers to ensure that concerns and strategies are focused to meet the child and family's current needs.

Five (5) working days prior to the six (6) month or annual IFSP, each service provider shall complete a summary of the child's progress and provide a hard copy to the child's parent or guardian in compliance with 902 KAR 30:130 Section 1 (11). Six (6) Month Progress Reports are entered in TOTS on the Progress Report screen. Specific data is required to support the description of progress that the child has made.

Providers are required to complete an exit or discharge summary. This summary describes the current developmental status of the child and summarizes progress achieved since the last formal progress report (six (6) month or Annual). The report should be entered on the Progress Report screen in TOTS.

D. General Documentation Requirements—Service Logs

All communication, including email and texts between team members about the family or direct communication with families becomes a part of the child's record by adding it to the communication log screen on TOTS (see the TOTS User Guide on TOTS for more information).

Each provider must use the service log in the child's TOTS record to document every date of service in compliance with regulation (902 KAR 30:200 Section 2, 3(a)). Documentation is required for billing verification and quality assurance purposes by First Steps, Medicaid and other payors. If a contact was scheduled but did not occur, a note should be completed noting the missed contact and any plan for future action.

Each service log must include a list of all those present during the session, a description of the Early Intervention Service(s) provided, the child's response and future action to be taken. The provider may also wish to include information related to how the parent or caregiver was involved in the session and any obstacles encountered during the session. When a child is seen primarily in a child care setting, it is the provider's responsibility to ensure the skills and behaviors the child is learning can be incorporated in the routines at home. The provider must communicate with

the parent on a regular basis, either by telephone or by a face-to-face visit to discuss the child's progress and how the parent has incorporated the interventions into the home routines. Each of these contacts must be recorded in the child's TOTS record. Because the primary audience in Part C is the family, it is important to use person-first language, avoid jargon, be respectful, and relate comments back to performance concerns. Parents can access service logs and reports on TOTS as well as receive or review a copy of the entire early intervention record maintained by the POE.

Service logs must be entered into TOTS within ten (10) calendar days of the date of service. After ten (10) days, the provider is unable to enter the service log and must contact the SLA for assistance. If this timeline is missed, there are penalties applied to payment.

E. Missed Visits

Given the frequency of illness in young children, family and provider vacations, and other unforeseen issues, missed sessions are inevitable. However, they should not be routine occurrences. Providers should make every effort to avoid missing service sessions. A "no show" is different from a missed visit. A "no show" is defined as a visit that was attempted but the family did not answer the door when the provider arrived. The parent did not give any prior warning or notice of unavailability. A "missed visit" is a visit that the provider had prior knowledge that the family, or provider, would not be able to keep the scheduled appointment. Missed visits must be offered as make up sessions to the parent since the IFSP is a binding document. A provider can reschedule a missed visit based upon the guidelines stated below:

1. If a weekly or monthly service session cannot be rescheduled within seven (7) calendar days of the original scheduled date, it should be considered a missed session.
2. Never provide a make-up session on the same date that a regular session has been scheduled if the total amount of time will exceed one (1) hour of service for the day. Do not split the total amount of time of the missed session across several subsequent visits.
3. If it is necessary for a provider to miss a number of service sessions due to an extended vacation or prolonged illness or injury, etc., the family should be given the option of selecting another equally qualified provider to fill in during the absence or go without the service for the length of the expected absence.
4. Always document in TOTS on the service log the date of the missed visit, the reason for the missed visit and if the visit was rescheduled based on the above guidelines.
5. Always bill for a make-up session based upon the actual date of service, not the date of the missed session.

Should a parent not want to make-up a missed visit, the provider must document this in the child's TOTS record in the communication log. Substitution of a service provider who is not authorized to provide services in First Steps is not allowed. Providers who arrange for this sort of coverage may face enforcement actions that could include recoupment of the monies paid, and/or contract termination.

F. Late Service Log Entry

Service Logs must be entered within ten (10) days of the provision of service to ensure good teaming and current record of services. TOTS will give an error message when entering a service log that is past ten (10) days from date of service. The SLA must assist in entering a late service log.

There are contract enforcements used in First Steps to ensure timely and accurate service log documentation. The Service Provider Agreement contains the regulatory language for prorating the reimbursement when the provider exceeds ten (10) days for service log entry (902 KAR 30: 200 Section 2 (3) (b) and (c)). The SLA starts a service log for the provider and marks the corresponding account payable event as disapproved. Once the provider enters the full service log detail in the correction/addendum box, the provider must contact the SLA to let staff know the note has been entered. The corresponding account payable event will then either be approved for payment or a note will be entered that it can be approved once an EOB is received.

The timing of the provider's notification to the SLA is very important and will directly affect the amount of reimbursement the provider will receive according to the following timelines:

- Correction entered and SLA notified within in five (5) days will be approved for payment at a \$3 reduction;
- correction entered and SLA notified within six to ten (6 to 10) days will be approved for payment at a \$8 reduction;

- correction entered and SLA notified within eleven to fifteen (11 to 15) days will be approved for payment at a \$25 reduction;
- correction entered and SLA notified within sixteen to thirty (16 to 30) days will be approved for payment at one-half the Maximum KEIS payment; and,
- correction entered and SLA notified beyond thirty (30) days will not be adjusted for payment.

Section C: Billing & Reimbursement

To be paid for services, providers must submit an invoice for the service rendered. This is called a claim. First Steps is the payor of last resort for Early Intervention Services. This means that all other funding sources must be utilized prior to submitting a claim (bill) to First Steps for Early Intervention Services.

Every service is identified in TOTS with a payor source:

- Payor 1—payment for services is supported by submitting claims to the entity identified as the primary financial resource. There are two primary payor sources Private Insurance or First Steps.
 - Private Insurance claims are billed by the provider to the insurance carrier and also submitted to First Steps.
 - First Steps claims are submitted by the provider to First Steps.
- Payor 2—this is the secondary financial resource for payment. Payor 2 may pay the remaining amount of a claim that Payor 1 did not cover up to the maximum KEIS rate.

Providers do not bill Medicaid for payment of First Steps services. First Steps bills Medicaid.

C-I: Submitting Claims for Early Intervention Services

A. Billing and Reimbursement Requirements

1. NPI Number

Each provider must obtain and submit a National Provider Identifier number (NPI) as part of enrollment in First Steps. The NPI is a ten (10) position, intelligence-free numeric identifier (10-digit number). The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. First Steps requires that all providers have an NPI because of the billing to insurance and Medicaid.

Agencies must have an NPI number for the agency as well as the NPI numbers for each employee that provides early intervention services. The agency number was submitted as part of enrollment.

To obtain an NPI or learn more about it: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>

2. Federal Tax Identification

Each agency must obtain and submit a federal tax identification number as part of enrollment First Steps. This number is used for tax reporting purposes and is used when billing insurance. An individual social security number cannot be used for insurance purposes.

To obtain a federal tax identification number or learn more about it: <http://www.irs.gov/Businesses/Small-Businesses-&Self-Employed/Employer-ID-Numbers-EINs>

3. Enrollment in Insurance as a Provider

All First Steps providers are required to enroll as an in-network provider for each child with private insurance listed as Payor 1. In-network providers are providers under contract with an insurance company that agree to provide services at a negotiated price. In-network providers may receive higher rates of reimbursement which is beneficial to both the provider and First Steps. Individual insurance company policies may provide some level of coverage for out-of-network claims. Out-of-network refers to providers not under contract with the insurance company. Some insurance companies will limit their coverage to in-network providers only. Evidence of the attempts to obtain network status must be filed with the SLA within 120 days of receiving a child on their caseload.

A denial for network status is not the same as a denial of payment for a claim. Providers who are not network providers for an insurance company file claims as an “out-of-network” provider.

B. Submission of Claim for Service on the Account Payable Screen

Services billed by time must be billed for the period of time that actual services were provided to the eligible child and/or family, and do not include time spent in travel to or from the setting. First Steps has established a rate of reimbursement that reflects a higher maximum rate of reimbursement for services provided in the natural environment.

The independent provider and/or agency administrator must submit the claim on the Account Payable screen in TOTS. Payment for the service from First Steps will be made if the billing is approved. The SLA processes claims in the order in which they are received. Claims processing may take seven to ten days.

Account Payable Screen

- Agency Administrator users and State Administrators can enter data on the Account Payable screen. (Independent providers are the administrators of their own agencies).
- The section labeled “Billed Amount” must be completed or the screen will not save.
- Agency Administrators can view the account payable records of the children their agency services.
- The Account Payable screen defaults to displaying billing events from the last sixty (60) days. To view older items, the user must click on “Show All Pending Account Payable” or “Show All Account Payable”.
- After the user clicks on SAVE, the entire screen is saved.

1. Creating a Claim for Payment: Individual (independent) Providers and Agency Providers

- Log on to the home screen in TOTS to view the dashboard. There is a link to “Service Logged Awaiting Payment”. Click this link to go to that screen. By clicking “Search”, TOTS will list all the children that have had a service log completed that has not been processed for payment. Then, click on “Detail” beside a child’s name from the list to be directed to the Accounts Payable screen.
- The claim to First Steps must be submitted within sixty (60) days of date of service or it cannot be paid. Insurance claims may be submitted to insurance simultaneously with claim submission to First Steps. If the claim to First Steps is submitted after sixty (60) days from date of service, the First Steps claim will be disapproved.
- There will be a list of items to be billed under “Approve Service Account Payable Below”. Each line will display this information taken from the Service Log and Planned Services screens:
 - Service Log ID
 - Service
 - Provider
 - Service Date
 - Hours
 - Rate (per hour)
 - Maximum KEIS Payment (rate multiplied by hour)
 - Service Note (a link to easily read the service log)
 - Correction/Addendum (will be displayed if any exists)
 - Planned Period
 - Planned Setting
 - Intensity/Frequency
 - Delivered Setting

The provider or agency administrator must enter the amount billed into the space provided for Payor 1, Billed Amount (name of payor displayed; if insurance, see page 30) and clicks SAVE.

Note: Providers develop their own schedule of rates for services. The provider must bill all payor sources at the same rate.

2. Claims Processing by First Steps

The SLA processes claims as described in the table below:

| | |
|--|---|
| Claims automatically approved | Claims with First Steps as Payor 1 <u>and</u> amount equal to or less than Maximum KEIS rate |
| Claims Reviewed for Approval by SLA | <ul style="list-style-type: none"> • Claims for Assistive Technology Devices (as approved by the AT Committee; see the First Steps Policy and Procedure Manual for information on this process) • Claims with an amount over the Maximum KEIS rate • Claims for assessments requiring data entry in KEDS • Claims with a date of service over 60 days past |
| Claims with Insurance as Payor 1 | Claims billed to insurance should be submitted on the Account Payable screen at the same time as billed to insurance. This action will ensure that the First Steps claim is submitted within the sixty (60) day timeline and saved. The claim will move to the Service Account Payment History section approved at \$0. The payment will be adjusted once an Explanation of Benefits (EOB) is submitted to the SLA. |
| Disapproved Claims | <p>Disapproved claims are marked in red and the reason for disapproval is entered in the Note box by the SLA staff.</p> <p>Provider must contact the SLA staff when the issue has been corrected. Correction <u>and</u> notification must be within sixty (60) days from date of service or claim will be denied.</p> <p>Disapproved claims that are later adjusted for payment are marked in gray with explanation of the SLA actions in the Note box.</p> |

3. Payment

First Steps staff runs the payment file according to a schedule posted on the First Steps website (<http://chfs.ky.gov/dph/firstSteps/needed+discipl.htm>). The payment file is sent to the Kentucky State Treasury for payment.

All providers who were paid through the TOTS system receive a 1099 form for the previous calendar year by the end of January from the Finance Cabinet. If this form is not received or the provider believes it is incorrect, contact the SLA for assistance. Corrections are issued by the Finance Cabinet.

4. Tracking Payments

Agency Administrators can check the status of payments for any child they have served through the Invoice Report. Click on Agency Invoice Report, then enter the start and end dates of the current billing cycle. These dates can be found on the First Steps website at <http://chfs.ky.gov/dph/firstSteps/needed+discipl.htm> . The report will show all items that have been approved or disapproved. If the item is still awaiting approval, it will NOT show on this report.

Agency's should run an Agency Invoice Report after each pay cycle as this is the only remittance statement for approved claims included within the billing cycle.

If details are needed to resolve a payment issue and the provider no longer has access to the Account Payable Screen, the provider can contact the SLA for the information (screen shots, copies of service logs or the account payable claim).

Users can also view Account Payable records on the individual child record. If an item is still awaiting approval, it will appear at the top with the billed amount entered.

C-II: Billing when Insurance is Payor 1

The federal law that governs First Steps, Part C of the Individuals with Disabilities Education Act of 2004 (IDEA), requires that Part C be the payor of last resort for the early intervention system established by the state. Parents must provide written consent to bill private insurance for early intervention services. The state cannot deny early intervention services based on a family's inability to pay or parent's refusal of consent to bill insurance.

Providers are required to bill insurance as part of the contract they signed when enrolling as an early intervention provider. Public insurance (Medicaid) is billed by the SLA on behalf of early intervention providers. If a child is covered by both private insurance and Medicaid, the private insurance is primary payor and must be billed before Medicaid (secondary payor) can be billed.

First Steps offers a no-cost insurance claim submission service, TOTS Insurance Billing Service (TIBS). This service submits the insurance claims on behalf of the provider, either electronically or on paper. Please see the Resources section at the end of this manual for more information on use of TIBS.

Providers should follow all steps to submit a claim for service through TOTS. As soon as the claim has been submitted on the Account Payable screen, it is recommended that an insurance claim also be submitted. Do not delay submitting a claim to First Steps while waiting for an EOB from insurance. All claims must be submitted within sixty (60) days from the date of service regardless of payor source.

TIBS Users

TIBS users submit a claim through TOTS. The claim will be included in file that is sent through an insurance clearinghouse, Availity, for submission to the insurance company. There is no need for a CMS 1500 to be submitted to the insurance company by the provider. Claims that are rejected by the clearinghouse are flagged and SLA staff works with the provider to resolve the issue. SLA staff submit the claim manually should the insurance company does not accept electronic claim submission on behalf of the provider. Date the manual claim was submitted by the SLA will be noted on the Account Payable page in the note box for the claim.

TIBS users can create a profile for the Availity web portal access to see submitted claims. To set up an Availity account, follow the instructions at <http://www.availity.com/register-now-for-web-portal-access/>.

NON-TIBS Users

Providers who are not using TIBS submit claims to insurance themselves. A CMS 1500 form can be generated by TOTS. This is accessed from the Account Payable Screen for the child who has insurance. If all the required fields are entered by the Service Coordinator on Financial Support, Demographic and Parent Screens then the fields on the CMS 1500 will be filled in (prepopulated).

Sections of the form detailing the service provided must be completed by the provider. See the Resource section at the end of this document for instructions on how to complete the CMS 1500.

NON-TIBS users may also submit insurance claims electronically using billing site such as Availity, MD On-Line, or ZirMed.

A. Co-payments and Deductibles

First Steps providers are not to collect co-payments and deductibles for First Steps services. Families do not pay providers directly for any service in First Steps. First Steps includes co-payments associated with the early intervention services in the First Steps reimbursement rate.

B. Billing Insurance:

Step one: Providers confirm that the family's insurance information is complete on the child's IFSP. This information will appear on the child's financial page in TOTS and in the notes section of the child's IFSP. This information must include:

- Full name of the policy holder
- Date of birth of the policy holder

- Insurance company's name and the name of the managing company, if different from the insurance company
- Policy and group numbers
- Provider's line/phone number(s) for claims/questions
- Fax line for claims/questions
- Mailing address for claims/questions

Note: If the financial information is incomplete or inaccurate, notify the Service Coordinator and POE manager.

Step Two: Providers complete the service log in TOTS to document the service provided and submits a claim on the Accounts Payable Screen. The family's private insurance is listed as Payor Source 1. The insurance company that covers the child is listed in the banner section of the TOTS screen. The provider must enter the amount billed to the insurance company in the pending account payable section and SAVE. This action will create an approved claim at \$0.00.

In the notes section on the Account Payable screen, the provider notes that the claim for this service has been submitted to the family's private insurance. The date of the claim's submission and method of submission should be included in the note. By submitting this to First Steps at this time, the provider is making First Steps aware that the service has been provided and has an approved claim within the 60 day timeline for claim submission to First Steps.

Step Three: Provider submits the EOB from the insurer to the SLA for processing. First Steps will not adjust the payment for the service until a copy of the insurance plan's EOB has been submitted.

1. Explanations of Benefits (EOB)

An Explanation of Benefits (EOB) is a document issued by the family's private insurance company that reports services the policy covers and the amount paid to a provider for a service claim. The family receives the EOB for each claim that their insurance carrier has processed. The provider of the service usually receives a Remittance Advice (RA) or a copy of the EOB. For First Steps processing, a RA or EOB must be obtained for all services provided by the First Steps provider for the child.

The EOB or RA will reflect the actions the insurance company has taken on the claim. The provider sends the EOB or RA to the SLA for processing. If the EOB or RA indicates a payment equal to or more than the First Steps rate for that service, then the approval is processed. First Steps will track the amount paid by the insurance company. The provider keeps the insurance payment in full. If insurance paid an amount less than the First Steps rate, First Steps will pay the difference between the insurance payment and the First Steps rate for that specific service. The provider receives the full First Steps rate for the service.

- a. If the family's insurance policy does not cover the type of service submitted on the claim, an EOB that states denial of such service can be provided for the duration of the child's current IFSP. In this situation a new EOB (with denial from the family's insurance company) must be obtained for each new IFSP plan date (every six months or new insurance year).
- b. Remember that each insurance company has its own open enrollment period and changes may occur to family's private insurance plan at any time (beginning, middle or end of calendar year). Do not assume insurance will always cover a particular service and likewise that that particular service will always be denied.

2. Insurance Denials

First Steps accepts denials for insurance payment when the service is not covered by the policy and will adjust payment to reflect the appropriate KEIS rate of reimbursement. Some EOBs will indicate no payment but the claim was applied to the deductible. This means that the service is covered by the policy; First Steps will pay the provider the appropriate KEIS rate of reimbursement. The provider must continue to bill insurance throughout the plan.

C. Tracking Insurance Claims

On the Agency Administrator dashboard of TOTS, under “Reports” is the *Pending Insurance Claim* button. This is a listing of all unprocessed insurance claims. Claims included in this report indicate that the SLA has not received an EOB for processing.

D. Claim Adjustment for Overpayment or Underpayment:

In cases of overpayment from the SLA to the provider, the provider will not refund payments manually through submission of a check. The adjustment will be entered on the system against individual claims and the system will deduct the amount of overpayment on subsequent claim(s) payments processed.

In cases of underpayments, adjustments will be entered on the system against individual claims and the system will augment the amount of the underpayment on the next claim payments processed.

If a claim has been entered involving insurance and a late payment from insurance was received, please contact the SLA for assistance.

Billing Timelines/Deadlines

Claim Filing Deadline:

Claims must be submitted within sixty (60) calendar days of the date of service. Remember, claims can only be submitted on the Account Payable screen; entering a service log is not submitting a claim.

Claim Resubmission Filing Deadline:

Previously submitted and disapproved claims must be resubmitted within sixty (60) days of the date of service by notifying the SLA. Exceptions to this are made only when exceptional circumstances exist.

Reminder: Never submit a claim for services that were not provided. This is an illegal practice will result in the loss of a provider’s contract as well as investigation by the Inspector General Office of Medicaid. Incarceration, loss of licensure, and debarment from Medicaid are examples of what may happen if a provider is found to be billing fraudulently.

E. Insurance Billing Errors

First Steps providers are responsible to submit “clean” claims. First Steps requires the provider to resubmit a corrected claim when there are errors cited on the EOB. Correctable errors include:

- Missing CPT and/or ICD-9 code(s)
- NPI number/taxonomy invalid
- Pre-authorization required
- Requested documentation not submitted by provider/family
- Network status paperwork not on file with SLA
- Wrong insurance billed; claim sent to wrong claim processing office
- Unreadable fax received

If the family’s insurance policy does not cover the type of service submitted on the claim, evidence that the insurance plan does not cover the service must be provided to the SLA. An EOB is the easiest evidence to obtain as it is specific to the family and policy. This evidence indicates that the provider attempted to obtain insurance payment. The evidence is kept on file and the provider does not have to re-submit this evidence during the time period of the IFSP (no more than six (6) months).

If no EOB is provided by the insurance company within a reasonable time period (60 days), the provider must try to obtain a written statement of denial in lieu of the EOB or RA. The provider must notify the SLA of this situation. Verbal denials by an insurance company are rarely approved by the SLA. With approval of the SLA, the provider may submit to the SLA the name of the insurance company, the name of the representative with whom the provider talked, the phone number, the reference number assigned by the insurance company, and the dates of attempts to get a written

statement. The provider will be required to sign and date an Attestation Form which shows that the provider understands that all information about the denial is true and that there are sanctions that the SLA may take if the information is found to be false.

Providers may submit complaints to the Department of Insurance if a fully-insured plan refuses to process a claim and issue payment or a denial.

F. Insurance Payments to Families (Policyholder)

Some insurance companies will issue the EOBs and any payment to the policyholder when the provider is not in-network with the insurance. Providers need to work with the family to obtain the EOB and payment.

If the check issued by the insurance company is still intact, the following steps should be followed:

- a. The policy holder (i.e. the person to whom the check was issued) should sign the check over to the provider. This is done by writing "Pay to the order of . . ." followed by the provider's name and the endorsing signature of the policy holder on the top of the back of the check.
- b. The provider then faxes a COPY of the check AND the EOB the family received from the insurance company for services rendered by that provider to SLA.
- c. SLA will complete any recoupment that is applicable.
- d. Provider is free to cash or deposit the check received from the insurance company via the family.

If the family cashes the check from the insurance company without making arrangements to pay the provider for services:

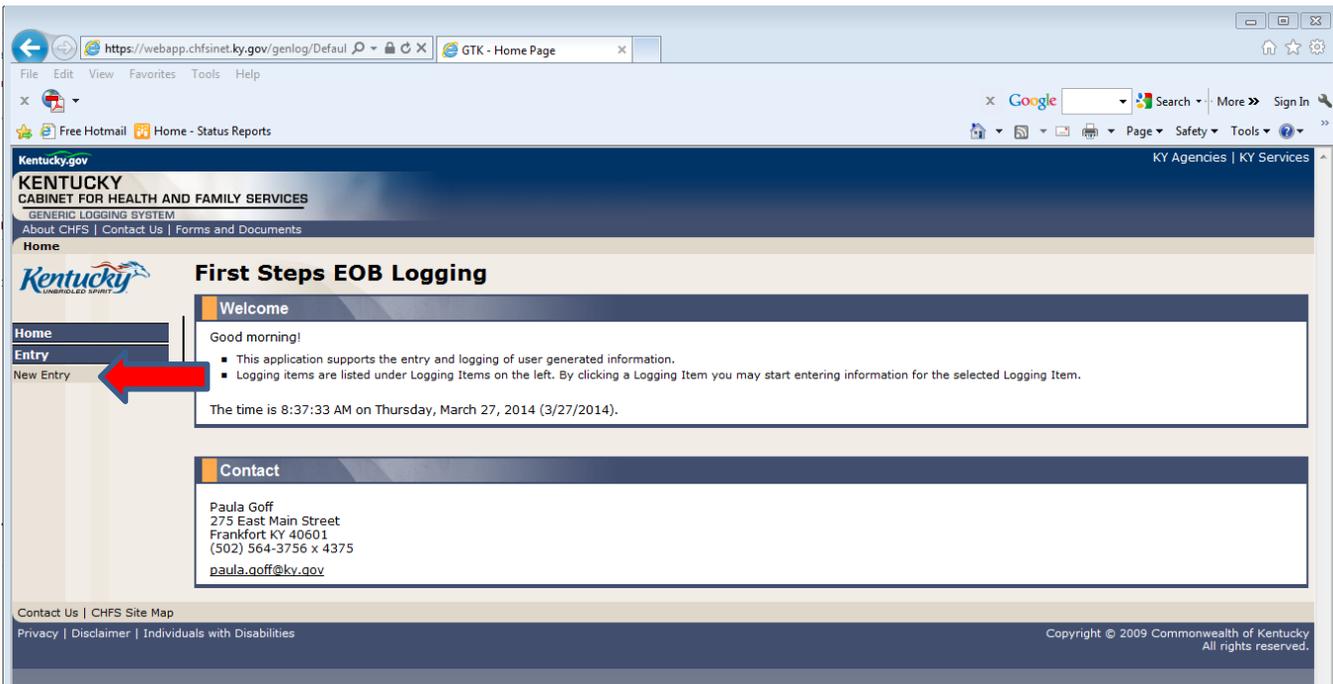
- a. The provider should contact the SLA to report what has happened.
- b. The provider then faxes a copy of the EOB the family received from the insurance company for services rendered by that provider to the SLA. If no EOB was received, the provider must send proof of their attempts to collect funds from the policy holder and the following information from the insurance company to the SLA. The information must include the following:
 1. Date of service
 2. Amount paid
 3. Check number
 4. Date check cashed
- c. The SLA will contact the family to discuss recoupment of the insurance funds.
- d. The provider is paid by First Steps for the service rendered.

G. Submitting EOBs to the State Lead Agency

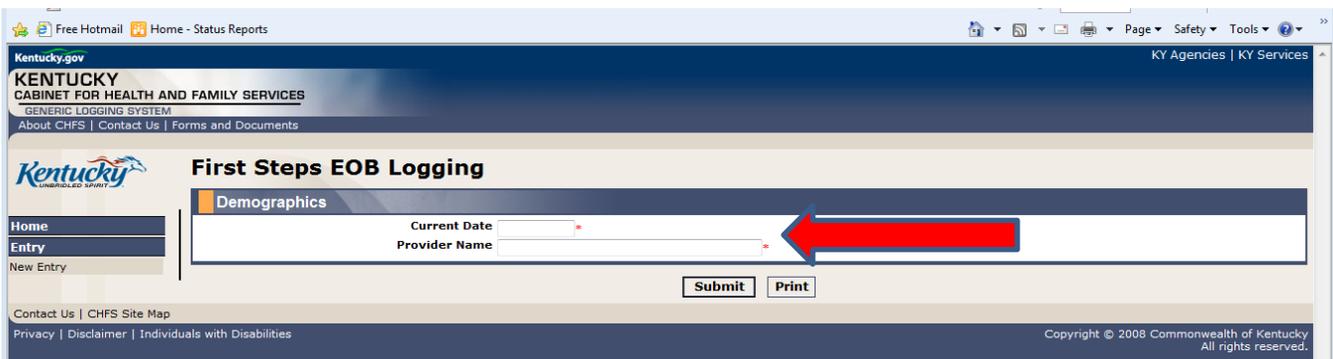
Providers may submit EOBs by uploading a scanned PDF or picture of the EOB to the Genlog website or by faxing the EOBs to the SLA office.

Uploading to Genlog

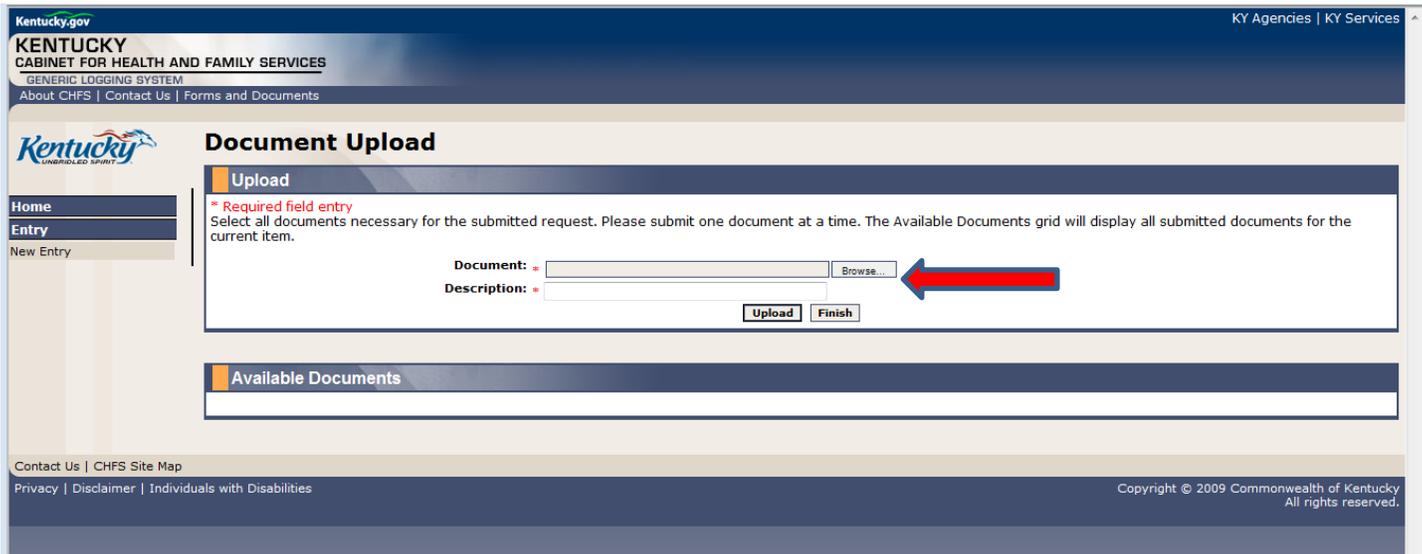
1. Provider scans or takes a picture of the EOB and saves this on their computer. Please check the scanned EOB before saving to ensure that it's readable.
2. Provider goes to the First Steps GENLOG site by clicking this link: <https://prd.chfs.ky.gov/genlogex/Default.aspx?TK=67>. Be sure to bookmark this link.
3. The first screen is the welcome screen. To upload an EOB, the provider clicks on "New Entry" found in the list on the left under the heading Entry.



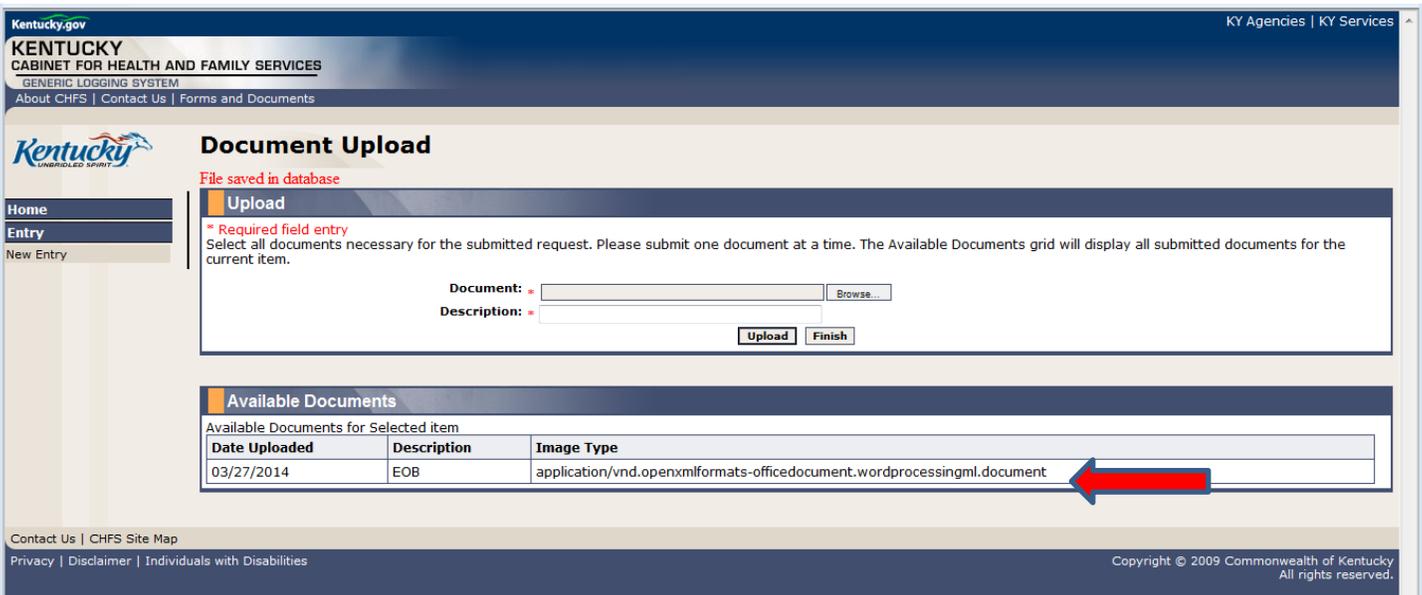
4. Once at the First Steps EOB Logging screen, enter the provider name or agency name and current date in the respective boxes and click “Submit”.



5. On the next screen, click BROWSE to locate the saved EOB on your computer and then click UPLOAD. The provider enters the TOTS identification number in the “Description” text box when submitting EOBs for one child. Multiple EOBs for several children must be labeled “Group EOBs”. No more than approximately 50 pages of scanned documents can be uploaded at one time.



6. The uploaded file is displayed in the section labeled "Available Documents". Once the user clicks "Finish", EOB submission is complete.



7. An automatic notification is emailed by GENLOG to the SLA announcing that a new EOB has been uploaded.

H. Faxing EOBs

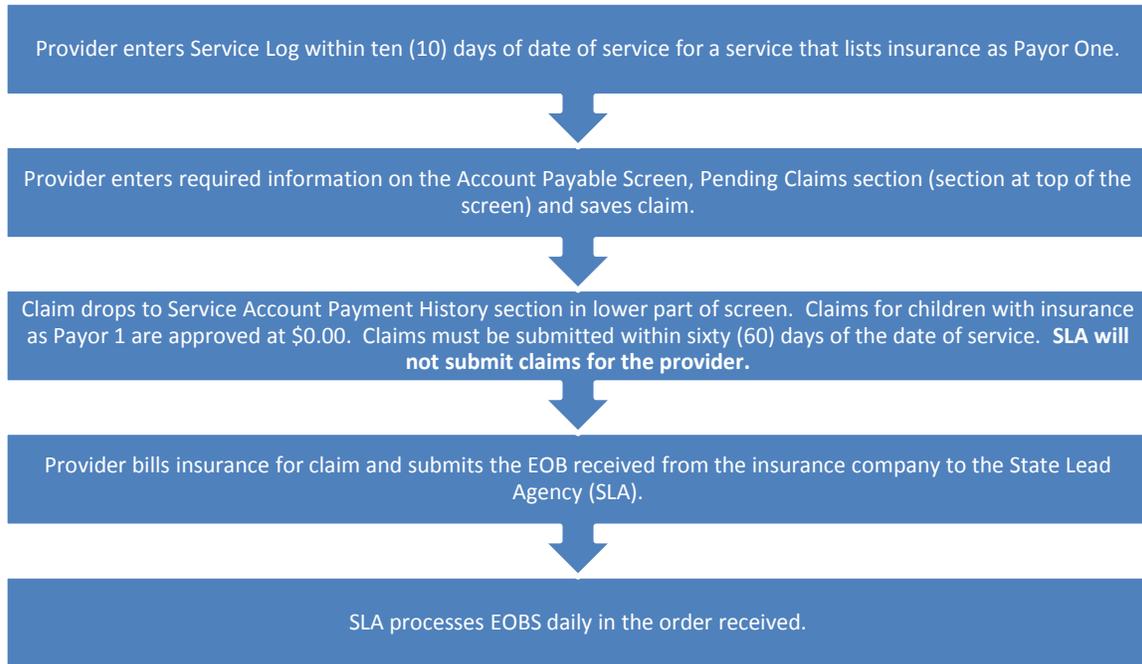
EOBs may be faxed to the SLA at **502-564-0329**. Be sure to protect the confidentiality of the child by using a cover sheet that lists only the TOTS identification number on it. EOBs that have clients outside of First Steps listed must have any client's name not enrolled in First Steps redacted.

C-II I. Insurance Audits/Quality Assurance

Periodically insurance companies conduct a review of the payments made to providers as a routine practice for quality assurance. First Steps providers may be asked to provide additional information to the insurance company as part of the review. The insurance company may recoup funds from the provider if the result of the review is that payments were made in error or they may pay for services that were originally denied or not paid. **It is the provider's responsibility to inform First Steps of any change in payment by the insurance company.**

- **Insurer recoups previously paid funds:** The provider submits a copy of the letter from the insurer with a copy of the provider's check that indicates payment to the insurer to the SLA. The SLA will then adjust the provider's payment based on the insurer's action.
- **Insurer pays for services previously denied or not paid:** Provider submits a copy of the letter and check from the insurer to the SLA. SLA will then recoup funds previously paid by First Steps.

SLA First Steps Insurance Processing



Appendix

Important Contacts

TOTS Screen Shots

Insurance Billing Resources

Important Contact Information

| Topic/Subject | Email | Phone Number | Website |
|--|------------------------------|--|---|
| First Steps General Information | chfs.firststeps@ky.gov | 502/564-3756 | http://chfs.ky.gov/dph/firstSteps/default.htm |
| First Steps Provider Enrollment | chfs.firststeps@ky.gov | 502/564-3756 | |
| First Steps Billing | CHFSFirstStepsBilling@ky.gov | 502/564-3756 | https://prd.chfs.ky.gov/genlogex/Default.aspx?TK=67 |
| ➤ To upload EOBS | | | |
| ➤ To FAX EOBS | | 502-564-0329 | |
| First Steps TOTS Support | chfs.firststeps@ky.gov | | |
| Department of Insurance | | 502-564-6034 800-595-6053 (Option 1) | http://insurance.ky.gov/Home.aspx?Div_ID=4 |
| Kentucky One Stop Business Portal | | | http://onestop.ky.gov/Pages/default.aspx |

Appendix 1: TOTS Screen Shots

Service Log Screen

Service Log Information

Child ID: 79305
Child Name/DOB/Age In Months: Test Child - 12/14/2011 - 28 months
Child Status: Active
Phase: IFSP

Select an IFSP to Add Service Log (if it is not on current IFSP): Pending -

(Note: If the current IFSP is pending and your service is not ISC, PSC, Evaluation or Assessment and your service is in the current IFSP, you will not be able to enter service log. In this case, please contact service coordinator to finalize the IFSP)

Add Service Log:

| *Service | Provider | Planned Period | Planned Setting | Frequency | Length (hours, or miles) |
|---|----------|----------------|-----------------|-----------|--------------------------|
| <input type="button" value="Select Service ..."/> | | | | | |

| *Actual or Missed Service Date | *Service Delivery Status | *Start Time | *End Time | *Actual Setting | CPT Code | ICD Code | *Service Note/Description of Intervention(3880 chars left) | Correction/Addendum |
|--------------------------------|---|---------------------------------------|---------------------------------------|---|--|----------------------|--|---|
| <input type="text"/> | <input type="radio"/> Service Delivered <input type="radio"/> Absence Due to Family <input type="radio"/> Absence Due to Provider <input type="radio"/> Family No Show | <input type="text" value=" (hh:mm)"/> | <input type="text" value=" (hh:mm)"/> | <input type="button" value="Select Setting ..."/> <small>(Lower rate applies to non-natural environment - EI Center, Hospital/Clinic, Other)</small> | <input type="text" value=" (CPT code)"/> | <input type="text"/> | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> |

Service Log (Default to Service Date within 60 days)

- District Administrators, Service Providers and Service Coordinators can view, edit, or add to this screen.
- **IFSP:** This defaults to the current plan. If the current plan is PENDING, or if there has been a very recent plan entered, the user may need to choose the previous plan from the drop down list. The user should choose the most recent plan under which the service was authorized.
- **Service:** The user chooses the service provided from a drop-down list populated from Planned Services of the IFSP chosen above.
- TOTS will then display the **Provider** and **AT Device** if applicable, **Planned Period**, **Planned Setting**, **Frequency** and **Intensity** in hours or miles for transportation.
- If you try to enter a service log and cannot find the correct service or date available from the drop-down, DO NOT try to proceed. Contact the Service Coordinator immediately for assistance!
- If this service requires an **Interpreter**, TOTS will display a drop-down list for the user to select who or how this was done. In addition to the names of interpreters, the list includes choices for:
 - A No Show by Interpreter—provider and family decide whether to reschedule or proceed
 - A Provider/Service Coordinator as Interpreter—the user speaks the language
 - A Service Coordinator w/o Interpreter Needed—Service Coordinator made a call or visit without the family present
- **Actual or Missed Service Date** is in the format of mm/dd/yyyy and must fall between the Planned Period start and end dates.
- **Present or Absent:** All of the following choices require a service note of explanation:
 - Service Provided
 - Absence Due to Family
 - Absence Due to Provider
 - No Show—family was not there at agreed time.
- **Start time** is in the format of HH:MM and it uses 24 hours format; **End time** is in the format of HH:MM and it uses 24 hours format. If a provider bills for one hour of service, the provider must have actually delivered that full hour of service. Rounding up of time for billing purposes is not allowed.
- **Actual Setting** should typically be the Planned Setting, but can be chosen from this list:

| Setting | Definition/Example |
|-------------------------|-----------------------------------|
| ○ Family/Guardian Home | Child’s home |
| ○ Daycare Provider Home | Care provider’s home |
| ○ Daycare | Daycare center (typical children) |

Posted May 2015

Page 38

- | | |
|-------------------|--|
| ○ EI Center | Early Intervention Center |
| ○ EC Center | Early Childhood Center |
| ○ Community | Parks, library, grocery store, preschool, etc. |
| ○ Hospital/Clinic | Medical facility or clinic |
| ○ Other | POE office provider's office, parent's workplace, etc. |

Payment rates vary based on setting. If services are provided in a setting that is NOT the child's natural environment, the rates are reduced. The following are paid at the lower rate: EI Center, Hospital/Clinic, and Other.

- **Service Log:** The user enters a thorough explanation of the service or missed visit. For Intervention services only, TOTS will supply the following required fields:
 - Date of Service
 - Delivery Status
 - Start Time and End Time
 - Actual Setting for Service—location where the service was delivered.
 - CPT Code: This is procedure code for the treatment provided during the service. Early intervention service providers must enter the code correctly.
 - ICD Code: This is the diagnosis code that the provider is addressing; this may be different than the medical diagnosis of the child and must be specific. Early intervention service providers must enter the code correctly.
 - Service note / Description of intervention—what happened during this visit?
 - Delivery method –check all that apply: Modeling, Assessment, Coaching Caregiver, Providing Resources) and Co-treatment. If co-treatment was provided, additional information is required:
 - Co-treatment? (Yes/No) With? Name of co-interventionist(s). This does not affect billing. Both interventionists should enter a service log for the same time, both providers document that it is a co-treatment, and both bill their full rate.
 - Participants in this intervention visit—who was there? This also documents natural environments. For example, the daycare is a natural environment but taking the child to a room alone away from the other children is not. This would change the setting to a non-natural environment. A daycare visit should show the involvement of at least one adult caregiver and other children.
 - Caregiver report—what has happened since last visit?
 - Response to intervention—how is the child progressing; are interventions working?
 - Plan for next visit—when, where, purpose?
- **Correction/Addendum** can be added after saving a service log if addition information needs to be included or if an error needs to be documented in the original note. Select “Edit” to make a correction or addition to a log. If the correction affects billing, the user should contact their agency supervisor or the SLA for assistance if needed.
- After the user selects SAVE, the entire screen is saved.
- **Service Log List** TOTS supplies a view of the service logs entered in the last 60 days by default. Logs are listed with the most recent on top. All users can view all service logs. To view older logs, the user must select “**Show All Service Log**”.

Instructions for correcting Service Logs:

Documentation in a child's TOTS record in a service log or communication log, once entered, is considered permanent and therefore shall not be altered. Before saving an entry, ask:

- Is this the right child?
- Is this the right service (collateral, assessment, intervention)?
- Is this the right date and time?
- Is this the right setting?

If a mistake is made, follow the guidelines below:

- Use the “Edit” key to pull the item back to the top of the screen.
- Enter the date of the correction and a note in the **Correction/Addendum** box to explain the error. Enter a clear and concise note such as:

- 03/23/14 WRONG CHILD, please disregard this entry.
- 03/23/14 WRONG SERVICE, the correct service type is OT Collateral.
- 03/23/14 WRONG TIME, the correct start and end time is 02:00-03:00.
- 03/23/14 WRONG DATE, the correct date is 03/21/2014.

Note: The text from the **Correction/Addendum** box will show beside the billing item on the **Account Payable** screen also.

- If the correction affects the amount of a bill to be submitted (for example, the correction results in more or less time to be billed) the billing must be adjusted accordingly. For example, if the original entry was for the wrong child, go to the account payable screen and enter a zero (0) in the amount billed and SAVE. Agency employees must notify the appropriate person within the agency who processes billing so that a correct billing is submitted by the agency. Agency supervisors must set policy within the agency on how this will be handled.
- If the correction affects the amount of a bill previously submitted, SLA assistance is required for correction. Just click on the SUPPORT key on the TOTS screen, provide a short explanation of the correction needed including the child ID number and click the SEND button. (Ex: For child #12345, please correct billing for service log #123456 as indicated in correction note.) SLA staff will correct the billing and send verification of the correction.

CMS 1500 Instructions

The CMS 1500 is a universal health care claim form and can be completed either electronically or in hard copy paper format. The paper copy must be completed and mailed to the claims address on the back of the insurance policy holder's card. There are many websites where CMS 1500 forms can be purchased for a small price.

Some insurance plans allow the use of an online portal to submit claims electronically. This information is available on the websites of individual insurance companies. The advantages of submitting a CMS 1500 online include ease of processing, receipt of results in real-time, quicker reimbursement, confirmation that an insurance company has received the claim, and no phone calls to check on the status of a claim (viewed online instead).

In addition to online portals, there are also insurance clearinghouses to which a provider can submit a claim. The clearinghouse will confirm the provider's claim is "clean" before electronically submitting it to the insurance company. The cost of using a clearinghouse ranges from free to approximately \$100 for a given number of claims submitted. Some examples of clearinghouses include Availity (www.availity.com) and Zirmed (<https://public.zirmed.com>).

CMS 1500 Completion Instructions

The CMS 1500 form located on the Account Payable page can be used to submit claims to insurance. **Fields 1 through 11B** will automatically be completed by TOTS for the child and parent information. **Field 12 Patient or Authorized Persons Signature** and **Field 13 Insured's or authorized Person's Signature** enter Signature on File or SOF. The policy holder's signature is not required on this form because it is on file in the hard copy record available through the POE office. **Field 14 through 20** and **field 22** do not have to be completed by the provider.

The chart below provides detailed information on completing the remaining sections of the CMS 1500 form.

| Field Number | Field Name and Description |
|--------------|---|
| 21 | Diagnosis or Nature of Illness or Injury Enter the ICD code that best suits the condition that the service provided addressed; this may be different than the primary medical diagnosis |
| 23 | Resubmission Code Leave this empty if the claim is not a resubmission |
| 23 | Prior Authorization Number Should be completed if the insurance company requires prior authorization for services. |
| 24A | Date of service (non-shaded area) Enter the date in month, day, year format (MMDDYY). |
| 24 B | Place or Service (non-shaded area) Enter "12" for home based service setting; Enter "99" for other service setting. |
| 24D | Procedures, Service or Supplies CPT/HCPSC (shaded area) Enter the CPT codes that best matches the services provided. |
| 24D | Modifier Optional--not commonly used with First Steps services. |
| 24E | Diagnosis Pointer Not commonly used with First Steps services |
| 24F | Charges (non-shaded area) Enter the rate for services, minimum billed charges must correspond to the MAX KEIS Liability from the Account Payable page |
| 24G | Days or Units (non-shaded area) Enter the number of units provided for the member on this date of service. Units are billed in 15 minute increments except for services by a speech language pathologist (SLP). SLP services are billed per procedures at a unit of 1 regardless of length of time. |
| 24H | EPSDT family plan Do not complete this area |

| | |
|------------|--|
| 24I | ID Qualifier Do not complete this area |
| 24J | Rendering Provider ID# Enter your NPI number |
| 25 | Federal Tax ID# Enter Federal Tax ID |
| 26 | Patient's Account No. Recommend the child's TOTS ID number be entered in this field. |
| 27 | Accept Assignment? If marked yes the provider is agreeing to accept the negotiated rate from the insurance carrier. We recommend that you mark this as yes. |
| 28 | Total Charges If multiple claims are filed on same form, enter the total amount of all claims. If a single claim is filed on the form, enter an amount that matches the 24F. |
| 29 | Amount Paid Providers enter \$0.00 to indicate no payment has been received. |
| 30 | RSVD for NUCC Use Do not complete this field. |
| 31 | Signature of Physician or Supplier including degrees or credentials A hand written signature is required. A designated signature such as an authorized representative is acceptable. A stamped signature is not acceptable. Date Enter the date in a month, day, year numeric format (MMDDYY). This date must be on or after the date(s) of service billed on the claim. |
| 32 | Service facility location information If applicable |
| 33 | Physician/Supplier's Billing Name, Address, Zip Code and Phone Number Enter your name, address, zip code and phone number (including area code) |
| 33A | Enter the provider NPI Number. Do not enter an agency NPI number. |
| 33B | Do not complete this area. |

CPT® Codes

CPT® (Current Procedural Terminology) codes are numbers assigned to every task and service a practitioner may provide to a patient including medical, surgical, diagnostic, and rehabilitation services. Since everyone uses the same codes to mean the same thing, they ensure uniformity. The codes are owned by the American Medical Association (AMA). Providers can go to the AMA website to purchase a CPT® code directory: <http://ama-assn.org>. Search "CPT® codes".

Providers use codes that most appropriately describe the services rendered. Insurance considers many of the services provided through early intervention as therapeutic services which may be associated with a CPT® code for medical or diagnostic services. The services may also be considered developmental, rehabilitative or restorative.

Commonly used codes by First Step providers

NOTE: The provider must research each and every code to ensure that the code selected is the correct code for the services delivered.

Developmental Interventionist (DI)

96152: Health and behavioral intervention

The intervention service provided to an individual to modify the psychological behavior, cognitive and social factors affecting the patient's physical health and well-being.

96153: Health and behavioral intervention

(More common for group DI services (2 or more patients))

The intervention service provided to an individual to modify the psychological behavior, cognitive and social factors affecting the patient's physical health and well-being.

Physical Therapy (PT)

97110: Therapeutic procedures, 1 or more areas, therapeutic exercises to develop strength and endurance, range of motion and flexibility

97116: gait training (includes stair climbing)

97530: Therapeutic activities, direct (one on one) patient contact by the provider (improve functional performance)

Occupational Therapy (OT)

97530: Therapeutic activities, direct (one on one) patient contact by the provider (improve functional performance)

97542: Wheelchair management (assessment, fitting, training)

95851: Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)

Psychology

96154: Health and behavioral intervention (family present)

Speech Therapy (SLP)

92507: Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

92526: Treatment of swallowing dysfunction and/or oral function for feeding

92508: Special Otorhinolaryngology Services (group, 2 or more)

Kentucky TOTS Insurance Billing Service (TIBS)

Q: Who may use TIBS?

A: Any First Steps provider agency that does not have an effective and efficient insurance claims process in place, and does NOT claim insurance for services outside of First Steps.

Q: Am I required to use TIBS?

A: No, TIBS is offered as a service to First Steps Provider Agencies, but no agency is required to use it. All agencies are, however, required to bill insurance if a family authorizes the use of insurance.

Q: How much does TIBS cost?

A: There is no charge to provider agencies for the use of this service.

Q: What must I do as a TIBS participant?

A: In general, TIBS users have the same duties as any First Steps Provider Agency:

1. Fulfill the requirements of the First Steps contract to attempt to become in-network with any insurer covering a child on your caseload and provide this documentation to the State Lead Agency (SLA).
2. Help the SLA maintain the Provider Matrix profile for all providers in your agency, including the insurance companies with which each is credentialed and in-network by reporting any changes or additions immediately.
3. Enter the amount you wish to claim for each date of service onto the Account Payable screen of each child's record within 60 days of the date of service and SAVE. This enters that claim into TIBS.
4. Fax EOB's to the SLA for entry into TOTS.
5. Cooperate fully with the SLA staff to resolve any denials or questions regarding insurance claims.

Q: How do I sign up?

A: Complete the TIBS enrollment form. The TIBS enrollment for First Steps must be mailed to the SLA with an original signature of the agency administrator.

TIBS Insurance Billing Procedure

Family Insurance Information

During intake, the family receives instruction regarding use of insurance for Part C services. If the family chooses to use their private insurance they provide the insurance information to the Service Coordinator, who documents the details on the Financial Information screen. The Service Coordinator assists family in choosing a provider in-network with their insurance company, using the Provider Matrix. The Service Coordinator obtains parent consent authorizing the use of their private insurance to pay for early intervention services. The Service Coordinator updates this information regularly and contacts providers if insurance changes. TOTS will maintain a record of previously authorized insurance payors, with end dates for their effective periods.

Service Authorizations

An IFSP is written and the provider is approved for service(s) on the Planned Service screen. The Service Coordinator checks "Permit Insurance" on the Planned Services screen for each service for which the family has approved that insurance can be billed, and indicates Private Insurance as Payor One and First Steps as Payor Two.

In-Network status with Insurers

Providers are contractually obligated to submit documentation necessary to become in-network with all insurance companies used by their clients. If the provider is denied in-network status, the SLA staff reviews the case record and determines whether to change Payor One back to First Steps.

Service Provision

Service is provided in accordance with the documentation on the IFSP.

Service Log Entry

Service log is entered, including ICD Code and CPT Code within ten (10) days of date of service. If the service log is not entered within ten days, the provider must contact the SLA for assistance by phone or email. Written Information is required to create a shell for service log entry. The SLA staff can facilitate the late entry process. **Service log entry is not service claims submission. Claims must be submitted on the Accounts Payable screen no later than 60 days from the date of service.**

Provider Insurance Billing

Provider enters item for payment: The provider agency enters the insurance claim amount on the Account Payable screen in TOTS, in no case more than (sixty) 60 days from the date of service. The provider only enters the amount claimed to the insurance company and SAVES. This should be the provider's usual and customary charge to all clients, and may reflect a charge higher than the maximum KEIS liability.

Late entries: Any billing that does not meet the criteria of being "entered within sixty (60) days from the date of service" is automatically denied by First Steps.

TIBS Submits Claim to Insurance

TIBS submits the claim for the item to the insurance company electronically. All claims will be submitted through a clearinghouse. In the case of an insurer that does not accept electronic claims; the SLA will submit the CMS 1500on behalf of the TIBS user.

Receipt of EOB

Insurers create an EOB (Explanation of Benefits) for the provider. EOB's may be received by the provider by mail or in some cases online at the insurer's website. Some insurance policies will only provide the EOB to the policyholder. In those cases, the provider will need to obtain the EOB from the policyholder. The provider is responsible for faxing, emailing, online submission, or mailing the EOB to the SLA, where it will be manually entered into TOTS along with any payment due the provider from First Steps.

Denials:

If an EOB shows a denial for a reason that is valid and will not change (i.e. that the child is not covered for that service), SLA staff pays the provider the Maximum KEIS liability and changes the Planned Services screen for that child to First Steps as Payor One. (A letter from the insurer may be substituted for an EOB if applicable.) The SLA staff member notes these actions in the text box provided on the child's Account Payable screen. The provider agency will see that this change has been made when next submitting a claim on the Account Payable screen. In this case, the provider agency will be able to directly bill First Steps for future provision of this exact service through the existing six month plan period. SC's must reauthorize insurance as Payor One at every six month or annual review to allow this process to be repeated. This is because insurance companies change their plans annually, some in January and some in July. Because First Steps must prove to OSEP that First Steps is the Payer of Last Resort, it is necessary to regularly verify whether changes in the insurer's plan might result in insurance coverage of services.

Resubmittal of Claim: If the EOB show a denial for a reason that can be addressed (i.e. a piece of information required on the claim form was omitted), SLA staff facilitates correction of the claim and resubmit. The SC, provider, or both may be contacted regarding corrections needed for resubmittal.

No EOB: If no EOB is received after 90 days from claim submission, TIBS will change the color on the AP screen to yellow. Also, TIBS will add this child to a list available on agency administrator's home screen that notifies the provider agency that they must contact the insurer for an explanation. The provider agency may then make any changes needed for resubmittal of the claim and notify the SLA to initiate a resubmittal, or submit evidence of a denial from the insurer along with a request for payment to the SLA by fax, email, or mail.

Duplicate payment: If the provider ever receives a payment from an insurance company for a previously First Steps-paid claim, they must send the EOB to the SLA staff, who will process a recoupment. **Failure to follow this guideline constitutes insurance fraud, and in some cases Medicaid fraud. The provider will be turned into the Department of Insurance and/or the Inspector General's Office of Medicaid for investigation. Termination of the First Steps contract may result as well as criminal charges and disbarment from Medicaid.**

Agency Invoice Report

The provider agency reviews the Agency Invoice Report, which documents all approved and disapproved items. The provider must go to the individual child's record for details, including the disapproval reason, if applicable. The provider may contact the SLA at any time to dispute or question the status of any item.



Provider Agreement for TOTS Insurance Billing Service (TIBS)

This agreement, is entered into and between the Commonwealth of Kentucky, Cabinet for Health and Family Service, Department for Public Health, Division of Maternal and Child Health (hereinafter referred to as the Cabinet) as the State Lead Agency for the Kentucky Early Intervention System and it's contractor Yahasoft, Inc., and: _____ hereinafter referred to as the Provider.

Name of Early Intervention Services Provider

The Provider understands that:

1. Enrollment in TIBS will mean that the provider may choose to enroll in the electronic remittance advice (ERA) system that the insurer offers but is not required to do so at this time. If the provider chooses to enroll for an ERA from the insurer, the provider understands that the ERA must be only for First Steps clients. The setup for ERA must be completed by the provider. The ERA agreement(s) must indicate TIBS (Yahasoft, Inc.) as the recipient of the ERA.
2. The Provider is responsible for submitting EOBs from the insurer or from the policyholder to the Cabinet for processing claims. TIBS will not receive paper EOBs or submit those to the Cabinet on behalf of the Provider.
3. Yahasoft, Inc. may require the Provider to complete additional paperwork specifically addressing issues for the operation as a billing agent for the Provider. The Provider understands that they will not be enrolled in TIBS until the paperwork is completed.

The Provider agrees to:

1. Fulfill the requirements of the First Steps contract to become in-network with any insurer covering a child served by this agency and provide documentation to the First Steps State Lead Agency (SLA).
2. Maintain the Provider Matrix profile for all providers in this agency, including the insurance companies with which each is a network provider.
3. Maintain a federal tax identification number for all claims submitted in TOTS. The provider understands that a social security number cannot be used for insurance claim submission in TIBS.
4. Enter claims for each date of service onto the Account Payable screen of each child's TOTS record within sixty (60) days of the date of service.
5. Submit EOB's to the SLA for entry into TOTS for insurers that do not use ERA.
6. Cooperate fully with the SLA staff to resolve any denials or questions regarding insurance claims. Failure to do so will result in disenrollment in TIBS. Agree to submit additional documentation required by Yahasoft (as the billing agent) to resolve issues regarding claim submission.
7. Maintain a physical address listed in TOTS; no Post Office Box can be used for insurance billing.

Agency Administrator Name: _____

Agency Administrator Signature: _____ **Date:** _____

Email Address: _____

Phone Number: _____ **Fax Number:** _____

For State Lead Agency Use Only

| | | | | | |
|---------------|--|----------------|--|-------------|--|
| Date Received | | Effective Date | | Approved By | |
|---------------|--|----------------|--|-------------|--|